The RHODE ISLAND MEDICAL JOURNAL

VOL. XXX OCTOBER, 1947 NO. 10

ABDOMINAL HYSTERECTOMIES PERFORMED AT RHODE ISLAND HOSPITAL, 1941 THROUGH 1945*

LT. (JG) ROBERT E. MARTIN, MC, USNR

The Author. *Lt. (jg) Robert E. Martin, MC, USNR, of Newport, R. I. Former Intern, Rhode Island Hospital, now Staff member, Department of Orthopedics, U. S. Naval Hospital, Newport.*

THE GYNECOLOGICAL LITERATURE contains many reports of the surgical mortality and morbidity following hysterectomy. By means of such statistics, some of these reports have endeavored to point out the superiority of either total or subtotal hysterectomy. This study, however, was undertaken to determine the mortality and morbidity following abdominal hysterectomy at the Rhode Island Hospital so that our results could be compared with those from other published reports.

This review includes all the abdominal hysterectomies performed at the Rhode Island Hospital between January 1, 1941, and December 31, 1945. The operations were performed by a large number of surgeons, both general and gynecological. With such a large number of surgeons involved, there were certainly nearly as many different techniques. Thus, there was no standardization of operative technique nor was there any standardization of indications for operation.

A total of 664 abdominal hysterectomies was performed—352 supravaginal and 312 complete. It was only in 1945 that the number of complete hysterectomies surpassed the number of supravaginal.

Chart I presents a resumé of the distribution of the operations throughout the years covered by the study.

Of the 664 patients, 20.5% had had some previous pelvic operation, including appendiceal abscess, peritonitis and D & C with insertion of radium.

CHART I
ABDOMINAL HYSTERECTOMIES
from 1941-1945

Year	*Complete*	*Supravaginal*	*Total*
1941	49	52	101
1942	58	92	150
1943	43	75	118
1944	61	84	145
1945	101	49	150
Total	312	352	664
Mortality	1 (0.3%)	3 (0.9%)	4 (0.6%)

At operation part or all of the adnexae were removed in 83.4% of the cases, while in the remaining 16.6% of the cases hysterectomy alone or hysterectomy and appendectomy was performed. Thirty-three plastic operations were performed at the time of hysterectomy and 19 miscellaneous procedures, which varied from simple umbilical hernia repair to extensive bowel resection.

The patients spent an average of 14.1 postoperative days in the hospital.

Symptoms

No systematic or thorough study of symptomatology was made. However, as far as possible, the chief complaint was recorded. In many instances where there was more than one complaint, the one which had presumably caused the patient to seek medical advice was recorded. Under the complaint "vaginal bleeding" have been included irregular menstrual periods, menorrhagia, metrorrhagia and spotting — in short, any variation from normal bleeding. Forty-nine per cent of the patients presented the complaint "vaginal bleeding". Abdominal pain was present in 23% and knowledge of a

continued on next page

*Read before the New England Obstetrical and Gynecological Society, April 30, 1947.

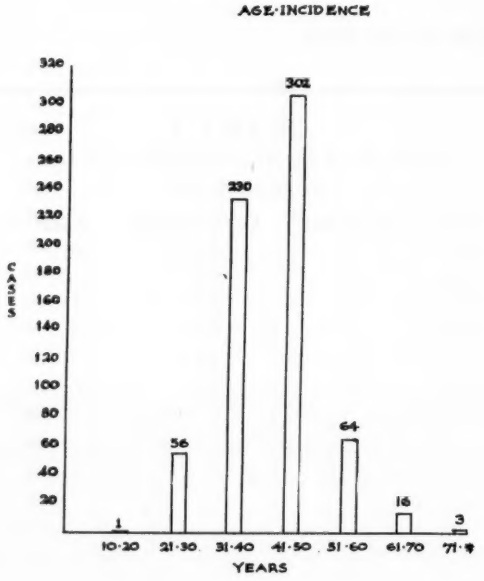
This study was made possible by the guidance of George W. Waterman, M.D., Chief, Department of Gynecology, Rhode Island Hospital.

pelvic tumor in 7.5%. Backache, dysmenorrhea, urinary complaints were each present in less than 5%.

Age

The ages of the patients ranged from 17 to 72, with the greatest majority between the ages of 31 and 50. Chart II shows the age incidence. Forty-five per cent of the patients were in the age group 41 to 50. The next largest age group was that from 31 to 40, containing 34.3% of the patients.

CHART II



The prevalence of hysterectomy in these two age groups corresponds to the predominance of myomata uteri as the most frequent pathological entity found. In the 21 to 30 age group and in the early 30's, residues of pelvic inflammatory disease was the predominating pathologic condition.

A summary of the pathological conditions found is presented in Chart III. In most of the cases more than one condition was present. The two conditions most frequently found together were myomata uteri and chronic cervicitis.

Malignancy of the pelvic organs was found in 39 cases, or 6.0%. Carcinoma of the endometrium was the largest single group, comprising 31 cases. There was one sarcoma of the uterus. One case of carcinoma of the ovary was due to extension from carcinoma of the uterus. The one case of carcinoma of the tube was also due to extension from uterine carcinoma. There were no cases of chorio-epithelioma or hydatidiform mole.

CHART III

PATHOLOGY PRESENT

	Number	*Per cent*
Myomata	373	55.2
Chronic cervicitis	237	35.3
Chronic salpingitis and or oophoritis	160	23.8
Adenomyosis	53	7.9
Endometriosis	46	6.8
Chronic endometritis	21	3.1
Endometrial polyp	70	10.2
Dysplasia of endometrium	46	6.8
No significant pathology	31	4.6
Products of gestation	20	3.0
Ectopic pregnancy	3	0.5
CARCINOMA		
Endometrium	31	4.6
Cervix	3	0.5
Tube	1	
Ovary	3	0.5
Serous cystadenoma of ovary	9	1.3
Pseudomucinous cystadenoma of ovary	6	0.9
Cervical polyp	19	2.8
Myoma & Adenomyosis	23	3.4
Dermoid cyst of ovary	4	0.6
Fibroma of ovary	4	0.6
Chronic appendicitis	206	30.6

Of the non-malignant conditions, myomata uteri was the most frequent, occurring in 55.2% of the cases. Next in order of frequency were chronic inflammatory changes, cervicitis, salpingitis and oophoritis. Chronic appendicitis was encountered frequently because of the almost routine performance of appendectomy.

Endometriosis occurred in 6.8% of the cases. Other observers have encountered up to 20% incidence of endometriosis. Here, however, only the pathological reports are considered. There were numerous cases where the operator described typical endometriotic lesions, but no pathologic report was made.

Adenomyosis was encountered in 7.9% of the cases; and in 43.5% of these, myomata were also found. Of the 53 cases of adenomyosis, 19% were accompanied by endometriosis.

Endometrial polyps were found in 70 cases, for an incidence of 10.2%. This finding is of interest because in a fair number of these cases endometrial polyps were the only demonstrable cause of vaginal bleeding. (Incidentally, curettage before operation was more common in the earlier years of this study than it was in the later years.) The condition most commonly associated with endometrial polyps was either chronic endometritis or salpingitis.

The term "no significant pathology" is used to designate no pathology, secretory endometrium, proliferative endometrium, corpus luteum, Graafian follicle or simple cysts of the ovary.

Morbidity

It is impossible to accurately compare morbidity figures with other reports because of the lack of a morbidity standard. Many standards have been devised, but none in use are wholly acceptable, for each has its obvious flaws. The most commonly used, however, are variations of the obstetrical morbidity standard of a temperature of 100.4° on any two days post partum. Some have adopted this directly substituting postoperative for post partum. The American College of Surgeons have used this, except that they exclude the day of operation. In this study a modification of this standard has been made. Our standard is a temperature of 100.4° on any two days postoperative excluding the day of operation and the first postoperative day. Using this standard we had a gross morbidity of 32.6%, in the complete hysterectomy group 35.0% and in the supravaginal group 30.0%.

Following the example of Jones and Doyle, we have regrouped the cases so that they fall roughly into seven large pathological groups, and we have tried to correlate the morbidity with the pathological group.

The seven groups are: (1) Tumors. These are benign neoplasms of the uterus or adnexae, not complicated by any other condition, such as residues of previous pelvic inflammatory disease, endometriosis or previous pelvic surgery. (2) Residues of previous pelvic inflammatory disease. This group includes all patients who had residues of previous pelvic inflammation, etiology not considered. All adhesions not explained on previous pelvic surgery or endometriosis were classed as residues. (3) Previous operations. This group includes associated pathology usually — adhesions from previous operations, but the patients did not have residues of previous pelvic inflammatory disease or endometriosis. The usual picture was myomata plus adhesions with a history of previous pelvic surgery. (4) Endometriosis. Included are all patients who had any endometriosis or adenomyosis without malignancy. A patient having a benign tumor and endometriosis was classed as endometriosis. (5) Malignancy. Any genital malignancy. (6) Insignificant pathology. Included in this group are functional bleeding, endocrine dyscrasia, dysplasia, proliferative or secretory endometrium without other pathology. (7) Chronic cervicitis and miscellaneous. In this study this group contained cases where chronic cervicitis was the main pathological diagnosis or was present, plus such conditions as retained placental tissue or endometrial polyps.

CHART IV

RELATION OF PATHOLOGY TO MORBIDITY

	Number	*Number Morbid*	*Per Cent Morbid*
Tumors	277	69	24.9
Residues	114	42	36.8
Previous operations	52	17	32.7
Endometriosis	77	29	37.7
Malignancy	39	10	25.6
No Significant Pathology	46	12	26.1
Cervicitis and Miscellaneous	65	33	50.7

Chart IV shows the relation between morbidity and the pathological groups. Because of the indefinite bounds of these groups only a general idea of correlation can be obtained. However, two points are evident; one is the relatively low morbidity in the benign and malignant tumors of the uterus and adnexae, and the second is the high morbidity in the chronic cervicitis and miscella-

continued on next page

CHART V

CAUSES OF MORBIDITY

ETIOLOGY	SUPRAVAGINAL		COMPLETE		TOTAL	
	Number	*Per Cent*	*Number*	*Per Cent*	*Number*	*Per Cent*
Hemorrhage	2	1.9	1	0.9	3	1.4
Urinary Infection	13	12.2	11	10.0	24	11.2
Thrombophlebitis	3	2.8	5	4.4	8	3.7
Wound Infection	10	9.4	17	15.6	27	12.6
Pelvic Infection	10	9.4	10	9.2	20	9.3
Pulmonary Emboli	2	1.9	0		2	0.91
U. R. I.	3	2.8	2	1.8	5	2.3
Unknown	63	59.2	57	52.0	120	55.9
Pneumonia	0		4	3.5	4	1.8
Distention or Obstruction	4	3.6	1	0.97	5	2.3

neous group. In this group were five cases of retained placenta and one of multiple endometrial polyps and chronic cervicitis. The remainder of the 33 morbid cases had only chronic cervicitis.

Chart V shows the cause of morbidity. The largest number was in the "unknown" group. Here either no cause of morbidity could be found or none was investigated. This group comprised 59.2% of the supravaginal group and 52.0% of the complete hysterectomy group.

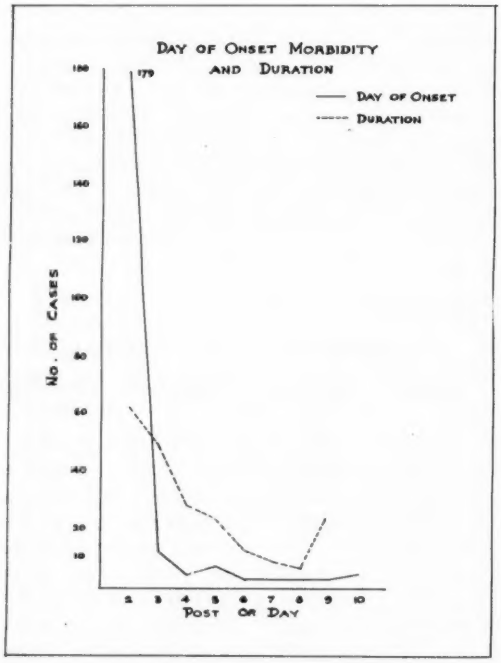
In the supravaginal group, aside from the "unknown", urinary infections were responsible for the largest single number of known cases, 13 (12.2%). Following this were wound infection and pelvic infection each 9.4%. There were two pulmonary emboli in the supravaginal group, neither was fatal. Thrombophlebitis was present in only three cases.

In the complete hysterectomy group there were 17 wound infections accounting for 15.6% of the cases, no proven pulmonary emboli, and four cases of postoperative pneumonia. There was no increase in urinary infection.

Chart VI shows graphically two things. The solid line represents the number of cases that became morbid on a given postoperative day. The striking fact about this graph is that 179 cases or 82% of the patients that were morbid had their onset on the second postoperative day. (The second day is the first one counted for morbidity in this study). There is then a precipitous drop to 12 cases or 5.5% on the third day. The slight rise on the tenth day is due to the fact that all those becoming morbid on or after the tenth day are considered together.

The interrupted line represents the number of days a patient was morbid. Thus, 28.8% were morbid for two days, 22.9% for three days and so on. The slight rise on the ninth day is due to the grouping of all those morbid for more than eight days.

CHART VI



MORTALITY

In the entire series of 664 cases there was a mortality of 0.6% (4 deaths). Three were in the supravaginal group, an incidence of 0.95%, and one in the complete group, an incidence of 0.32%.

The causes of death were: Two myocardial infarctions, one postoperative hemorrhage, and one peripheral vascular disease.

CASE I — 42 YEARS.

Indications for operation: Bleeding myomata.

Preoperative complications: Hypertension and myocarditis. She was considered a poor risk.

Operation: Supravaginal hysterectomy, salpingo-oophorectomy and appendectomy.

Course: The patient died on the fourth postoperative day of a myocardial infarction.

CASE II — AGE 48 YEARS.

Indications for operation: Myomata.

Preoperative complications: Diabetes and Raynaud's disease of a severe nature.

Operation: Supravaginal hysterectomy and bilateral salpingo-oophorectomy.

Course: On the fourth postoperative day the patient's body became cold and clammy. The left upper extremity turned dark purple and was pulseless. The patient went into shock and died. Cause of death was recorded as Raynaud's disease, vascular collapse and diabetes mellitus.

CASE III — AGE 29 YEARS.

Indications for operation: Myoma.

Preoperative complications: None. Patient was in excellent health.

Operation: Supravaginal hysterectomy, right salpingo-oophorectomy.

Course: On the first postoperative day the patient went into shock. She was explored on the second postoperative day and no bleeders were found. There was, however, oozing from the cervical stump. The patient improved briefly after this procedure. However, she went into shock again and died. Cause of death was hemorrhagic peritonitis.

continued on page 728

CORONARY THROMBOSIS AND DIET

FREDERIC J. BURNS, M.D.

The Author. *Frederic J. Burns, M.D., of Providence. Visiting Physician, St. Joseph's Hospital.*

THIS PAPER is being submitted as a primary one concerning the relation of blood cholesterol with coronory thrombosis.

For many years the association between the two has been well recognized and frequent observations of elevated blood cholesterol have been noted following coronary thrombosis. An evaluation of some of the observations seems to form a pattern that warrants further investigation.

Davis, Stern and Lesnick have reported a tendency to increased cholesterol levels in angina pectoris and in arteriosclerosis, findings with which my own investigation coincides. Dock compared the greater frequency of coronary thrombosis in the members of the American armed forces as compared with the English forces. He further compared the diets of the two forces and readily demonstrated the much higher cholesterol content in the diets of the American army. Well known to all is the relative frequency of the occurrence of coronary artery disease in diabetes and in hypothyroidism, both of which reveal elevated cholesterols. White believes that atheromata, through narrowing of the lumen or ulceration of the intima at the site, may be the cause of the thrombosis. From clinical experience, I believe it has always been a point of conjecture why an emotionally calm individual, who has shown no evidence of cardiovascular disease, is suddenly stricken with coronary thrombosis. Usually no explanation is available and in these particular types of cases surely nervous strain and hypertension can be discounted as the causes.

While the elevation of blood cholesterol does not appear in all cases of coronary artery disease it does appear frequently enough to raise the question, is cholesterol a factor in the disease. Various theories as to the cause of the elevation have been submitted, but none accepted by all.

If a metabolic impairment or an excretory handicap, or both, exist, and whether these are primary in the individual body as, i.e. a hereditary factor, or secondary to another process such as glandular disturbance it seems feasible that attempts should be made to correct the cholesterol level. Particularly does this seem true in view of White describing his finding coronary atheromata in the endarterium. Included here is a microscopic picture of a coronary whose lumen is practically occluded. The distortion is readily seen to be caused by the atheroma in which the vacuoles that held the cholesterol crystals are readily seen. This particular patient did not die of heart disease but it appears apparent that cardiac involvement would soon have made itself felt in view of such narrowing of the lumen.

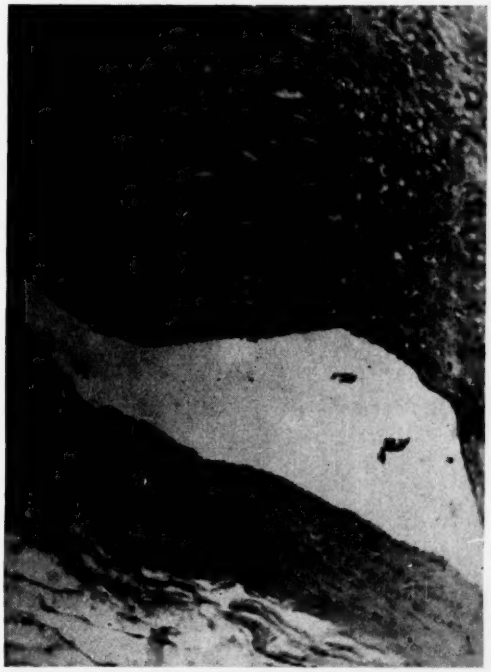


FIGURE I
Coronary artery atheroma (low power field)

The changing of blood cholesterol level is usually a slow process. Employing a diet presented by Dock, I chose four cases who have had coronary thrombosis. These cases were chosen in view of their intelligent cooperation and in view that they presented no other condition that would per se

continued on next page

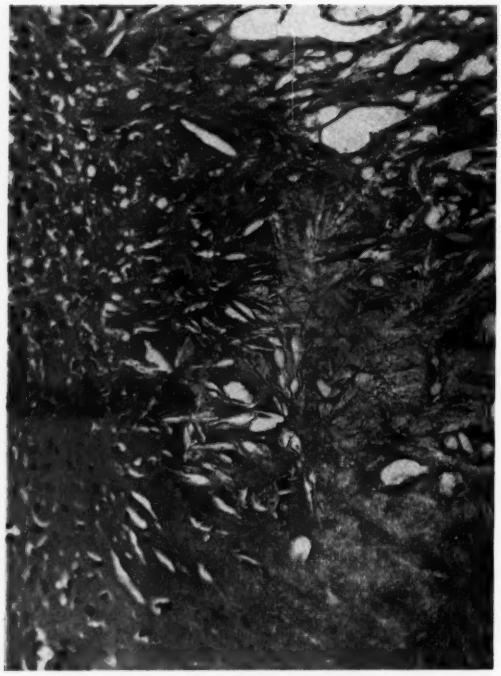
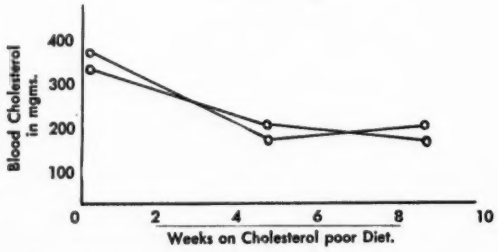


FIGURE II
High power field view of body of atheroma in Figure I

elevate the blood cholesterol. Two presented fasting bloods that showed normal levels. The second pair revealed definite elevations of 385 mg. and 345 mg. of cholesterol. As seen in the simple chart, both readily lowered their blood cholesterol by following their diet closely. At the end of five weeks, both were within normal range. A recheck four weeks later revealed normal findings in each case. Both patients find the diet not too restrictive. (Chart I)

CHART I



Considering the above it seems logical to me that there exists in many cases of coronary artery disease, either a state of faulty metabolism or excretion that may have a primary origin. In view of the location of the atheromata, the frequency of thrombosis in conditions that per se result in elevated cholesterol, and in view of these cases, granted too small in number to use as a criterion, that lowered their blood cholesterol by dieting, it seems as though such dieting would be of preventitive and corrective value. Realizing that wide investigation must be employed before accepting this as a fact, it seems reasonable that all patients with coronary artery disease should be investigated for cholesterol levels and attempts made to correct the abnormal ones.

ABDOMINAL HYSTERECTOMIES

continued from page 726

CASE IV — AGE 55 YEARS.

Indications for operation: Carcinoma of endometrium.

Preoperative complications: Hypertension and myocarditis.

Operation: Complete hysterectomy, bilateral salpingo-oophorectomy, repair of an umbilical hernia and cholecystectomy.

Course: Patient did well for 20 postoperative days. On the first day up out of bed she had a sudden precordial pain, went into shock and died. Cause of death was myocardial infarction.

Summary

We have attempted to present objectively the surgical morbidity and mortality following abdominal hysterectomy at the Rhode Island Hospital, and to add this report to the literature on this subject.

1. An analysis of 664 abdominal hysterectomies performed between January 1, 1941, and December 31, 1945, have been presented.

2. There were 312 complete and 352 supravaginal hysterectomies.

3. There were four deaths for a gross mortality rate of 0.6%; 0.95% supravaginal hysterectomy and 0.32% for complete hysterectomy.

4. Morbidity statistics have been presented and reviewed.

5. There was little difference in morbidity between the complete and supravaginal hysterectomy groups.

6. Uncomplicated benign tumors and malignant tumors of uterus and adnexae were associated with the lowest morbidity.

7. The pathological group "cervicitis and miscellaneous" was associated with a much higher morbidity than any other group.

BIBLIOGRAPHY

[1] Surgical Morbidity from Abdominal Hysterectomy, H.O. Jones & L. W. Doyle, Am. J. Obs. & Gyn., 46:160 July, 1943.

continued on page 733

USE OF CHOLINE CHLORIDE IN CIRRHOSIS OF THE LIVER, WITH RECOVERY AFTER 106 PARACENTESES.

LOUIS E. BURNS, M.D.

The Author. *Louis E. Burns, M.D., of Newport, R. I. Senior Staff Physician, Newport Hospital.*

THE PATIENT, Mrs. M. S., is white, married, 45 years old. Her health had been good, except for a left oophorectomy due to an ovarian cyst, and an appendectomy. There was normal birth of one child.

When I first saw her at the age of 40 in June of 1942, she had been drinking heavily for eight years — mostly hard liquor. She had previously enjoyed a good appetite and had been eating a well balanced diet. As her drinking progressed, particularly for the last few years, her appetite began to wane, and she confined her eating largely to soup and some white bread and pastry. She drank no milk, ate no cereals, very little meat, and then began to skip meals altogether — often had only one poor meal a day. She started early and drank just enough to keep a steady glow all day. Patient does not know why she drank, and now wonders how she lived at all on the small amount of food she ate. For some time she realized that she had not been feeling up to par, but could not get up courage to go to a doctor or give up her drinking. Finally she became so ill, medical aid was sought.

When she was first admitted to the Newport Hospital, Newport, Rhode Island, June 10, 1942, she was extremely weak, constantly tired, constipated, had developed a mild jaundice, itching of the skin (see icteric index Laboratory Sheet), indigestion, gas and nausea. On admission to the hospital, the use of intoxicants was stopped, and she has not had a drink since.

The physical examination was essentially negative, except for red, shiny tongue and cheilitis. There was an icteric tinge to the sclera, the abdomen was slightly distended and the liver palpable to four fingers below the costal margin. Pulse was 100, with daily elevation of temperature to between 100 and 101 every afternoon at four o'clock.

Treatment on the first admission was Vitamin B Complex ½ cc. and Liver ½ cc. (Lilly's) — both s.c. daily. Vitamin B Complex capsule one t. i. d. A high protein diet, with the least amount of fat possible, was ordered.

There was a clinical improvement. The jaundice decreased and the bile in the urine decreased from a 2 plus to a plus minus. After 14 days, the patient was discharged in ambulance, June 28, 1942, to continue above therapy at home. The final diagnosis was cirrhosis of the liver and hypovitaminosis.

The patient was admitted to the hospital for the second time on July 30, 1942. The abdomen was markedly distended, very slight icteric tinge to the skin, (see icteric index) tongue still red and cheilitis still present. The high protein diet, with low fat, was continued, with fruit juices ad lib. Vitamin B. Complex 1 cc. daily, Nicatinamide 100 mgs. t. i. d., Riboflavin 5 mgs. t. i. d. was given. (See Laboratory Sheet for red count, icteric index, low urea nitrogen, and low total protein with inverted A. G. ratio.

The first abdominal paracentesis was done August 6, 1942, in midline midway between umbilicus and symphasis with patient in sitting position, and 9000 cc. of slightly turbid fluid (2¼ gal.) was removed. She was tapped again on August 15, 1942, and 5½ quarts of yellowish fluid was obtained. On August 17, 1942, she was discharged to her home in ambulance to continue the above treatment.

Patient was admitted to the hospital for the third time for paracentesis only on August 25, 1942. The condition of the tongue and lips was the same, and the liver now extended down to the level of the umbilicus. Patient's abdomen was hard and distended, and she complained of severe pain in the lower back. Blood pressure was between 100 and 110. Medication was the same as on the previous admission. A paracentesis done August 26th obtained two gallons of dark amber fluid. She was discharged to home in ambulance to continue with the above treatments.

The first paracentesis was done August 6, 1942, and the last paracentesis on September 2, 1944. During this period 106 paracenteses were performed, an average of about six quarts of fluid being obtained each time. (Approximately 159 gallons in all.) The paracenteses done at home were performed with nursing nuns, the Sisters of the Holy Ghost (White Sisters) in attendance. These nuns also administered the daily therapy.

continued on next page

DISCUSSION AND TREATMENT. In order to replace the protein lost with each paracentesis, it was necessary to supply a tremendous daily intake of protein. If our thinking was correct, we had to have a high protein, high carbohydrate and low fat diet. If we depended on meat alone, the fat intake would have been too high, so we decided upon cottage cheese to keep the fat relatively low and supply a high protein intake. The patient ate a quarter of a pound of cottage cheese at least five times weekly, which she varied by adding jams and jellies. She drank at least a quart of skim milk a day, ate at least a half a pound of meat a day and more if she could get it. She was also given aminoids daily. All this food was divided up into three large meals and three small meals daily, and the patient observed "All I do is eat, take medicine, hypodermic injections, get tapped and try to sleep". During meat rationing, extra coupons were granted. We tried to keep the fat intake low.

By the addition of cottage cheese and skim milk to make up the protein, from the casein of cottage cheese we were adding the necessary methionine so essential in preventing deposition of fat in the liver and hemorrhagic degeneration of other organs,[1] shown experimentally by Griffith and Wade. This diet was adhered to for well over three years, when it was gradually modified to more nearly a normal diet, but still adhering to the high protein and moderate fat, with cottage cheese two to three times a week.

Liver injections unconcentrated (Lilly's) 1 cc. were given daily, also Vitamin B Complex (Lederle) 1 cc. daily, Brewers' Yeast Tablets 12 a day. After a visit with Dr. R. O. Muether,[2] in October, 1942, Choline Chloride grains 5 t. i. d. was started, made up with Elixir of Vitamin B Complex giving 5 grains to the dram. Patient got the liver injections and Vitamin B. Complex injections every day for three years, then we used it three times a week, then twice, then once a week and finally discontinued it in January, 1947. The Choline has been continued to date, although we have switched to the Choline Di-Hydrogen Citrate by Lilly. At present the Choline is the only medication given.

continued on page 768

LABORATORY WORK

Newport Hospital, Newport, Rhode Island

	June 10, 1942. First Admission	July 30, 1942. Second Admission	Aug. 25, 1942. Third Admission	June 16, 1947. Fourth Admission
Urine	2 plus bile otherwise negative	1 plus bile otherwise negative	1 plus bile albumen 1 plus	bile absent albumen plus minus otherwise negative
Kahn	Negative	Negative	Negative	Negative
Takata-Ara reaction	Negative			4 plus positive
Hemoglobin	80	82	80	89
Red blood count	3,580,000	3,930,000	4,030,000	4,240,000
Color index	1 plus		1 minus	1 plus
White blood count	7,100	5,900	8,500	3,700
Neutrophiles	72%	68%	71%	71%
Lymphocytes	28%	32%	29%	28%
Eosinophiles				1%
Icteric index	50	25		7
Coagulation time	4 min.			
Bleeding time	¾ min.			
Urea Nitrogen		7.5		
Total Protein		5.8		6.48
Albumen		2.6		4.31
Globulin		3		2.17
Sedimentation rate	28 mm in 60 min. There was a rapid even fall to 25 mm the first 45 min.			
A. G. Ratio		.9		1.9

CLINICOPATHOLOGICAL CONFERENCE

Rhode Island Hospital

Discussion by CHESTER S. KEEFER, M.D. of Boston, and B. EARL CLARKE, M.D.
***Pathologist*, Rhode Island Hospital, Providence**

NAME: R. T.
AGE: 31
ADMITTED: November 20, 1946

A 31-year-old white Jewish housewife was admitted to the hospital because of high fever and drowsiness.

The patient had apparently been well until three days before admission, at which time, she developed a fever. Her family physician prescribed ten white tablets which were presumably one of the sulfonamides. The following day her throat became sore. On the day of admission her temperature had become further elevated and she was lethargic. She had vomited a number of times. She denied having any cough, sputum, muscular pains or other complaints. There had been no known exposure to any communicable disease nor had there been a skin rash.

PAST HISTORY:

No serious illnesses.

FAMILY HISTORY:

No familial disease tendencies and no known exposure to tuberculosis.

PHYSICAL EXAMINATION:

Temperature 105.4 rectally; Pulse 130; Respirations 28; Blood pressure 115/65.

The patient was a normally developed, well-nourished, lethargic, acutely ill female. Her eyes were grossly normal with pupils that were equal and reacted to light. The fundi were normal. The pharynx was injected and two pustules were present on the hard palate. The neck was supple and there was no adenopathy or tracheal deviation. Her chest was resonant without rales and the breath sounds were vesicular. The heart was not enlarged and the rate and rhythm were normal. No murmurs were heard. The abdomen was soft, flat and no masses or organs could be palpated. The neurological examination revealed no pathological reflexes or paralyses.

An X-ray of the chest taken on admission revealed some slight haziness visible on the lower half of the left chest and obscuring the diaphragm. The cardiovascular outlines were normal. WBC 4,350 with 46% polys; 37% polysm; 17% metamyelocytes and 0% eosin. A blood culture taken on admission was sterile.

COURSE:

The following morning (11-21-46) patient was semicomatose with no deep reflexes demonstrable in her arms or legs. Her neck was somewhat resistant to flexion and there were suspicious reactions to the Kernig test on the right and to the Babinski test on left, but these were not considered positive. There was no clonus or paralyses. The abdominal, patellar and Achilles reflexes could not be elicited. There were two areas of ecchymoses in the right axilla and right upper arm.

A lumbar puncture revealed an initial pressure of 210mm, normal dynamics and final pressure of 80mm after 15cc of crystal, clear fluid had been removed. This fluid contained polys 0; lymphs 2; RBC 4; gave a negative Hinton reaction and a goldsol of 1111000000. The fluid was sterile with 18 mgm of protein, negative globulin and 120mgm of glucose. A throat culture was negative for hemolytic streptococci. A blood culture was sterile. WBC 5,850 with 74% polys; 23% lymphs; 3% monos; 0% eosin. Hemoglobin was 12.0. RBC 4.15. The results of agglutination studies were typhoid H positive 1:40; typhoid 0 positive 1:160; undulant fever negative. BUN 18; blood glucose 168. The blood Hinton test was negative and two blood cultures were sterile. Urine: Protein 2+; sugar 3+; acetone 0; RBC 0-1; WBC 1-2; casts 1-2 fine granular. A urine culture was sterile. The patient developed difficulty in swallowing and would bite anything placed in her mouth.

11-22-46—The third hospital day a neurological examination revealed no pathological reflexes. The optic discs were normal. The right triceps reflex was 2+, the left 1+. A stool culture was negative for dysentery, typhoid, pyocyaneus and paracolon groups.

11-23-46—A transfusion of 500cc of blood was given. A second lumbar puncture revealed an initial pressure of 190mm and a final pressure of 170mm after 6cc of clear colorless fluid was removed. The cell count of this fluid was 132 RBC, one lymph and it was sterile.

continued on next page

The patient's color was good. Respirations were noisy and there was considerable mucus in pharynx. A pelvic examination revealed no abnormalities except that she was passing some blood from her uterus. The catheterized urine was amber with specific gravity of 1.011; pH5; 2-4 RBC; 9-5 WBC; 2-11 coarse granular casts.

11-24-46—The blood smear showed 38% polymorphonuclear neutrophils; 30% metamyelocytes; 7% small lymphocytes; 22% large lymphocytes and 3% monocytes. The platelets were reduced and the red blood cells were normal. A transfusion of 500cc of blood was given.

11-25-46—There was a slight papular erythema over the malar regions, across the nose and on the chin. A transfusion of 500cc of blood was given.

The patient was given penicillin 50,000 units on admission and 40,000 units every three hours throughout her illness. Beginning on the fourth hospital day (11-23-46), in addition to the penicillin, 250mgm of streptomycin was given every three hours. She continued to be semicomatose throughout her illness. During the last two days she developed difficulty in breathing and was intermittently cyanotic. She continued to bleed from her vagina and there was bleeding from her mouth and nose. She passed a number of loose or soft brown stools incontinently during the period of her hospitalization.

Her temperature became lower by lysis to 102 rectally on the 4th hospital day and then dropped suddenly to 97 rectally. It remained slightly irregular between 98(r) and 101(r), until she expired on her 7th hospital day (11-26-46).

Discussion by CHESTER S. KEEFER, M.D. of Robert Dawson Evans Memorial Hospital, Boston

The central problem in this case is the explanation of the rapidly progressive fatal illness in a young woman of 31 years of age who was apparently well until 10 days before her death.

Let us review together some of the salient features of the history.

This patient was in good health until 3 days before admission, when there was a sudden departure from health with the symptoms of an acute infection and sore throat. She received some medication without relief and was admitted to hospital. There was nothing in either the past or family history to contribute to the present illness.

The examination showed the following: There was high fever, tachycardia, slightly elevated respiratory rate and a normal blood pressure. There was no evidence from examination that the patient had had any chronic illness preceding the acute episode since she was well nourished and normally developed. She was lethargic and acutely ill, but there were no localizing signs of disease on physical examination to enable one to make a specific clinical diagnosis.

The X-ray of the chest disclosed some visible haziness over the lower half of the left chest obscuring the diaphragm. There was a leukopenia with 17 per cent metamyelocytes and a sterile blood culture.

The course of her illness may be summarized as follows. Soon after admission to hospital, she became semicomatose, and the deep reflexes were absent, and two areas of ecchymoses were noted, one in the right axilla and the other over right upper arm. A lumbar puncture showed a moderately increased pressure, but the spinal fluid was normal. On this day, we are told that the white blood count was normal, along with the differential count. There was a slight anemia. The other examinations were essentially negative. She then developed difficulty in swallowing. There was no further change in the neurological examination on the third day. On the fourth day a blood transfusion was given. A second lumbar puncture was done and the pressure was slightly elevated and was reduced only slightly following the removal of 6 cc. of fluid containing 132 red blood cells and one lymphocyte. The increased RBC may have been traumatic. It was then noted that she was passing blood from the vagina. The following day, 30 per cent metamyelocytes were noted and the platelets were reduced. A transfusion of 500 cc. of blood was given on two successive days. Penicillin and streptomycin failed to change the course of the illness. She continued to be semicomatose, developed difficulty in breathing, and had bleeding from the mouth and nose as well as the vagina. The temperature was irregular during the period of hospitalization.

The diagnosis then must account for the acute onset with sore throat, high fever, bleeding into the skin and from the mouth and nose and vagina, the low platelets, the metamyelocytes, the stuporous state.

The first diagnosis I want to mention is an acute leukemia. The blood smear was not characteristic of leukemia in all respects, since there was no anemia, although this feature might have been masked by the blood transfusions and the acuteness of the process. The low platelets were consistent with the diagnosis as were the hemorrhagic phenomena, the sore throat and the high fever. The semicoma and other neurologic lesions may be accounted for by the associated intoxication or by hemorrhages into the brain.

The second possibility might be a purpura hemorrhagica secondary to some infection or of some unknown cause. The hemorrhages, and the low

platelets are consistent with such thoughts, but in general, patients with purpura hemorrhagica have bleeding at the outset and many petechial hemorrhages as well as ecchymoses; while fever may be a feature, it is infrequent in my own experience to see purpura hemorrhagica begin in this way, and run this course.

I return, then, to acute leukemia, as the most likely diagnosis in spite of the lack of certain features that might well clinch the diagnosis, such as a typical leukemic blood picture.

Let us review some of the salient features of acute leukemia. The diagnosis of this disease is usually based upon three main points: 1) the clinical features; 2) the blood picture; and 3) the course of the disease. It is confirmed at necropsy by finding leukemic changes in the bone marrow and other tissues.

First of all, I shall say something about the clinical features. It is a disease that tends to produce symptoms abruptly. It is seen most often in childhood and adolescence, and early adult life although it is occasionally seen in the elderly or aged. The sex distribution is about 2 males to 1 female. There are two common features that call the patient's attention to the disturbance: 1) a febrile illness with a sore throat or ulcerative stomatitis; 2) excessive bleeding following a tonsillectomy or tooth extraction. Bleeding may occur from other organs, such as the nose, vagina, or gastro-intestinal tract. Less often the disease announces itself with a rapidly progressive anemia, or a febrile illness with nausea, vomiting, abdominal distention, diarrhea and bloody stools, or in rare cases by neurological symptoms such as a bilateral facial palsy or a cerebral hemorrhage.

The blood picture usually clinches the diagnosis. The characteristic features are 1) a rapidly progressing anemia, 2) an increased leukocyte count with a differential formula showing a predominant number of immature cells, 3) a decrease in the platelets. Early in the course of the disease the red blood count and hemoglobin may not be greatly depressed. The leukocyte count may not be over 10,000 in more than half the cases, and in 3 to 5 per cent no myelocytes are found in the peripheral blood. The clinical course of the disease is one of rapid deterioration with death following in most cases in a period under 4 to 8 weeks. In the cases reported by Warren, death occurred within 2 weeks of the onset in 18 per cent of the cases. No treatment is effective. Multiple blood transfusions or radioactive phosphorus may be palliative but the end is always the same. *This is a dramatic disease.* It is a disease that often makes the newspapers, and creates great anxiety and distress.

The features of this patient's illness that suggest leukemia were the acute onset of a febrile disorder with a sore throat, the rapid deterioration with semicoma and stupor, the bleeding from the nose, mouth and vagina, the bleeding into the skin. The blood picture was not wholly characteristic in that the anemia was only moderate and there were only a few atypical and early myelocytes in the peripheral blood, although the platelets were reduced.

The clinical features and course of the disease were consistent with the diagnosis of acute leukemia, but the blood picture was not absolutely characteristic in all respects. The sum of the evidence then suggests to me that the most likely diagnosis was acute myelogenous leukemia.

My final diagnosis will read:

Acute myelogenous leukemia
Symptomatic P. H.

Discussion by B. EARL CLARKE, M.D., *Pathologist*, R. I. Hospital, Providence

The significant postmortem findings are in the kidneys and the heart. The kidneys exhibit typical features of a lesion which has recently been designated by Luckè as lower nephrom nephrosis. There is in addition a peculiar interstitial myocarditis and some arteritis of myocardial vessels (demonstrates gross and microscopic findings).

Lower nephron nephrosis is associated with a number of conditions including shock caused by various types of injury, blood transfusion reactions, and sulfonamide intoxication. This patient had blood transfusions but there is no reason to suspect a reaction. In any case I do not know of such cardiac lesion being found in cases dying of transfusion reaction. Sulfonamide intoxication on the other hand does result in both types of lesion. I suggest that the "pills" given before admission were sulfonamide and that the patient died as a result of sulfonamide hypersensitivity. Bone marrow and other organs exhibit no evidence of leukemia.

ABDOMINAL HYSTERECTOMIES

concluded from page 728

2 Total Abdominal Hysterectomy, W. C. Danforth, Am. J. Obs. & Gyn., 52: August, 1946.

3 Total Hysterectomy, J. L. Foss, Ann. Surg. 121:680, May, 1945.

4 Morbidity and Mortality from Abdominal Hysterectomy, D. Ashton, Am. J. Obs. & Gyn., 40:123, 1940.

5 Morbidity and Mortality from Hysterectomy, P. H., Smith, Am. J. Obs. & Gyn. 40:118, 1940.

6 Morbidity & Mortality after Hysterectomy, J. H. Phillips, Am. J. Obs. & Gyn., 50:174, August, 1945.

7 Control of So-Called Unexplained Infections in Surgical Wounds, D. Hart & J. Moody, S. Clinics N. Am., October, 1946.

8 Adenomyosis of Uterus, Brines and Blain, S. G. & O., 76:197, January, 1943.

9 Place of Surgery in Myomata Uteri, C. W. Barrett, Am. J. Surg., 66:148, November, 1944.

The RHODE ISLAND MEDICAL JOURNAL

Owned and Published Monthly by the Rhode Island Medical Society,
106 Francis Street, Providence, Rhode Island

PARTICIPATION IN THE SURGICAL INSURANCE PROGRAM

THE RHODE ISLAND MEDICAL SOCIETY, by action of the House of Delegates, has adopted a voluntary prepaid surgical and obstetrical insurance program. The plan is not fool-proof. It may reveal some flaws as its administration is started; but it is as sound and practical as advance study can make it.

The program won't work — unless the medical profession of Rhode Island actively participates.

Participation means several things. Foremost, it means signing the agreement with the Society to accept the charges for services included in the master schedule of surgical indemnities as the complete fee for persons below a set income limit. This action does not restrict any physician in the exercise of his right to refuse to treat any patient for appropriate professional reasons. It does mean the physician will abide by the rulings of the society's Health Insurance committee which will include a representative of each of the district medical societies.

Secondly, participation by the physician means that he will not abuse the indemnity feature of the program as applied to persons in the income groups above the limits set by the Society. The total bill for services to persons liable for any additional fee should be consistent with the usual fee prevailing in the community for that service. To act otherwise will not only jeopardize the surgical plan, but will also prove disasterous from a public relations viewpoint for the entire Profession.

Thirdly, the participating physicians should accept the responsibility of encouraging their patients to purchase insurance contracts. This task does not call for a detailed merchandising job for the busy doctor. It merely requires that he promote the program for the advantage of the patient and himself. If the threat of bureaucratic federal control of medicine is to be dissipated it will only be accomplished by showing that the voluntary method not only can work if given the chance, but actually does.

The stakes are high. The protection of the American standard of living is threatened. Medicine is meeting the first onslaught, and failure to prove its case will pave the way for the downfall of other phases of our democratic system.

That is why we look with optimistic hope to the insurance industry, encompassing the accident, health and life groups, to aid us in making this program a success. American insurance companies have the respect of the public. They form a bulwark against economic disasters far greater than any government agency ever could. Experience

has been gained by the insurance industry in a plan similar in some respects to ours in Wisconsin. That knowledge, plus the broad and comprehensive principles set forth by us, should make the Rhode Island program a pattern for the country at large.

We also look to the own Blue Cross organization, with whom we did not see eye to eye relative to the mechanics proposed for administering a surgical program for us earlier this year, to recognize in our latest proposal an opportunity to expand its community service by participation in merchandising surgical contracts. The success it has attained in the hospitalization insurance field should enable Blue Cross to promote lively competition with other insurance companies to the advantage of the public seeking insurance to meet the cost of surgical care.

Participation by industrial leaders and organized labor groups forms another major movement which we shall seek for the success of our program. Industry has made long strides in recent years in its development of fine in-plant health and safety programs, including not only the removal of employment hazards but also the care of industrial accidents by professional personnel working in well-equipped first aid rooms.

Many employers have of their own accord granted liberal hospital and medical care services as part of an employment contract. Others have taken the action at the insistence of labor groups bargaining for wage contracts, and then have recognized the value and the importance of the benefits to their workers. The Rhode Island Medical Society surgical insurance program should appeal to industry and labor alike.

Employer, employee, insurance company representative, physician—all have vital roles to play in making the new program a success in Rhode Island. But the physician is the most important participant.

GENERAL PRACTITIONER

NEWS ITEM: On Jan. 7 the American Medical Association will give a gold medal to a general practitioner selected from the country at large.
Dear Medical Ass'n.,

I been hoping you'd do something like this for over 35 years, and I'd like it to be our family doctor, who has been doctoring us ever since we thought the first baby was a tumor.

You probably never heard of him. He's not one of your big men—never invented anything in a medical way except a little spool and darning needle gadget for removing ingrowing hairs, and the only time he got into your journal, he says, was the time he had a queer fever of his own. But I feel better the minute he comes into the house, for he doesn't come to see a lot of organs, he comes to see ME. He knows me—knows us all—inside and out, warts, scars, disposition, everything. He knows I can't eat tuna fish, that I get flighty with two degrees of fever, and overdo everything from mowing the lawn to drinking beer. And somehow he manages to add all these things up to make me feel like somebody. I don't believe I'd ever be an "interesting case" to him no matter what I got. I'd just be me. That's really something these days. I don't have to call on him often, but I'd be lost without him.

He's a grand all-round man, good story teller, good listener, good friend, a sort of father confessor with the aid of a stethescope. It's unbelievable the good he's done in our neighborhood. A lot of people owe him money. I'd certainly like to see him get the medal.

Yours sincerely,

Almost Anybody

. . . Editorial Reprinted from the Providence Evening Bulletin, September 19, 1947.

STATEMENT OF THE OWNERSHIP, MANAGEMENT, CIRCULATION, ETC., REQUIRED BY THE ACT OF CONGRESS OF AUGUST 24, 1912, AS AMENDED BY THE ACTS OF MARCH 3, 1933, AND JULY 2, 1946

of *Rhode Island Medical Journal*, published monthly at Providence, Rhode Island, for October, 1947.

State of Rhode Island } ss.
County of Providence }

Before me, a Notary Public in and for the State and county aforesaid, personally appeared Peter Pineo Chase, M.D., who, having been duly sworn according to law, deposes and says that he is the Editor-in-Chief of the *Rhode Island Medical Journal* and that the following is, to the best of his knowledge and belief, a true statement of the ownership, management (and if a daily, weekly, semiweekly or triweekly newspaper, the circulation), etc., of the aforesaid publication for the date shown in the above caption, required by the Act of August 24, 1912, as amended by the Acts of March 3, 1933 and July 2, 1946 (section 537, Postal Laws and Regulations), printed on the reverse of this form, to wit:

1. That the names and addresses of the publisher, editor, managing editor, and business managers are: Publisher, Rhode Island Medical Society, 106 Francis Street, Providence 3, R. I.; Editor, Peter Pineo Chase, M.D., 106 Francis Street, Providence 3, R. I.; Managing Editor, John E. Farrell, 106 Francis Street, Providence 3, R. I.

2. That the owner is Rhode Island Medical Society, 106 Francis Street.

3. That the known bondholders, mortgagees, and other security holders owning or holding 1 per cent or more of total amount of bonds, mortgages, or other securities are: None.

4. That the two paragraphs next above, giving the names of the owners, stockholders, and security holders, if any, contain not only the list of stockholders and security holders as they appear upon the books of the company but also, in cases where the stockholder or security holder appears upon the books of the company as trustee or in any other fiduciary relation, the name of the person or corporation for whom such trustee is acting, is given; also that the said two paragraphs contain statements embracing affiant's full knowledge and belief as to the circumstances and conditions under which stockholders and security holders who do not appear upon the books of the company as trustees, hold stock and securities in a capacity other than that of a bona fide owner; and this affiant has no reason to believe that any other person, association, or corporation has any interest direct or indirect in the said stock, bonds, or other securities than as so stated by him.

PETER PINEO CHASE, M.D., *Editor-in-Chief*

Sworn to and subscribed before me this 18th day of September, 1947.

JOHN E. FARRELL, *Managing Editor*
(My commission expires June 30, 1954

[SEAL.]

THE RHODE ISLAND MEDICAL SOCIETY, through its policy making body, the House of Delegates, has approved of a program for voluntary prepaid non-occupational surgical and obstetrical insurance which it plans to submit to all duly licensed insurance companies and the Blue Cross to increase the extent to which insurance against the cost of surgical care is made available to the people of this State.

The Society, through its various committees, has given the problem intensive study for many months. The report of the surgical study committee as submitted to the House of Delegates represents a new and, we believe, an outstanding approach to the question of providing insurance at the lowest practicable cost to meet surgical expenses.

The fundamental reason for the program is to assist the person with a low or moderate income. Therefore, the Society is asking its members to subscribe to an agreement with it to provide complete surgical service for persons whose annual family income is under certain limits. These are the people for whom we are most concerned in our efforts to alleviate what is spoken of as the costs of catastrophic illness. For persons above the income limit our program, as does the voluntary hospitalization plan for its subscribers, provides an indemnity fee to be applied towards the total cost.

As the Committee has noted in its report the program will have its flaws. Experience, however, will enable us to improve the plan, and the Society is creating a permanent Health Insurance Committee, statewide in its representation, for the purpose of taking appropriate action upon administrative matters and complaints of insured persons or physicians. All policies under our program must be approved by the Rhode Island Medical Society prior to their sale.

The Society will extend all its efforts in the next three months to seek the adoption of this program by all insurance groups and Blue Cross. Our new Health Insurance Committee has been authorized by the House of Delegates to act with authority, and we confidently look forward to the sale of policies approved by the Society by January 1, 1948.

We hope that the program will attain the success it warrants if we are all to support the voluntary process of providing for personal health and welfare. For the Society the program is contemplated as the first step towards what it ultimately anticipates will be a complete medical care program available at the lowest possible cost under the highest standards of medical care in Rhode Island.

ARTHUR H. RUGGLES, M.D.
President,
Rhode Island Medical Society

REPORT OF THE SURGICAL INSURANCE PLAN STUDY COMMITTEE OF THE RHODE ISLAND MEDICAL SOCIETY TO THE HOUSE OF DELEGATES

(As Adopted By the House of Delegates, September 15, 1947)

At the January, 1947, meeting of the House of Delegates of the Rhode Island Medical Society it was voted that a committee of five members be appointed "to study ways and means of putting in effect a Rhode Island Medical Society low-cost prepaid surgical plan as of its own, or through the possibility of having a private insurance company take the plan over."

The Committee was subsequently named by the House of Delegates and it held its organization meeting on February 10 at which time Dr. Rocco Abbate was named chairman.

From the start of its study the Committee has approached its task with a wealth of data accumulated by previous committees of the Society that labored long and zealously on the problem of prepaid surgical insurance. The Committee is indebted to these previous committees for their files of information that aided materially in reaching the conclusions advanced in this report.

The Committee has carefully noted its instructions from the House of Delegates. It has viewed the processes necessary for establishing a program under the Society's own administration and it has viewed the development of such plans as Mutual Medical Insurance, Inc., of Indiana, and Ohio Medical Indemnity, Inc., in which stock or mutual insurance companies were organized by agencies of the medical profession in order to accomplish what was sought under the proposed enabling legislation.

The Committee has been fully cognizant of the difficulties that beset the Society in its previous negotiations aimed towards the development of a program under the supervision of a single insurer. Therefore, the Committee has endeavored to explore the field of private health and accident insurance for a possible new answer to the Rhode Island problem.

According to the Health and Accident Underwriters Conference more than forty million persons were covered under some form of health and accident insurance at the end of 1944, representing a five-fold increase over 1934 when about eight million people were insured. The total has steadily increased in the past two years. The wide actuarial experience that has been gained, plus the competition resulting with the advent of pre-payment medical care plans sponsored or approved by the medical profession, has resulted in new approaches to the extension of this form of coverage by private insurance companies.

Our preliminary proposal to all insurance companies licensed to do business in Rhode Island in which we utilized the indemnity schedule previously accepted by the House of Delegates, and added an agreement including policy provisions, met with an immediate response. The Conference Committee on Health Insurance, organized a year ago by the insurance industry for the purpose of conferring with representatives of the medical profession and hospitals in the development of insurance plans in the health insurance field, asked if it might meet with us. We agreed to hold discussions with this conference committee, and we have found their approach to our problem sympathetic and cooperative. Private insurance has already gained much experience in a plan somewhat similar to ours in the state of Wisconsin; but what we had set forth, and what we have since developed, contemplates far more than has been outlined by any other state medical society.

Your Committee holds the strong belief that if its proposal will be accepted by all the major insurance companies in the health, accident, and life groups, the competitive sale of contracts to provide for the payment for surgical and medical care on a prepaid basis in this state will result in the lowest cost possible on a sound, actuarial basis. We have not looked with favor on several recent plans whereby a single insurance company has been given the approval of a state medical society as the sole merchandising agent for surgical-medical insurance in that state. We believe that only through competition can rates be brought low, and only through the availability of several insurers can there be a guarantee against a monopolistic plan that might remain static.

However, the approach to any program of surgical or medical insurance warrants consideration of many factors. The Committee calls to your attention at this time some phases of this problem in Rhode Island that are generally overlooked, and yet are certainly basic issues that must be recognized and admitted as part of the program.

continued on next page

Difference Between Hospitalization and Surgical Insurance

First we would direct attention to the wide difference between hospitalization insurance and surgical-medical insurance. The success of the Blue Cross hospital program has created a popular impression that a surgical plan can be as simply operated and as successfully promoted. In our opinion this is not true. The hospitals, as community institutions of long standing, are well organized, and are planned to provide a specific service that is primarily institutional. Further, the hospitalization program needs only to contract with a dozen institutions for a limited number of specified services towards which it will pay a cash indemnity for the patient requiring those services.

In the surgical plan, however, the program calls for the services by approximately a thousand individual physicians in their offices, the patients' homes, or in the hospitals, and for several hundred different procedures for which the fee varies according to the type of operation. This plan, then, calls for a far greater problem of administration, and consequently involves an administration cost, under whatever sponsorship, that must affect the premium charged.

The Female Employment Problem

Secondly, and of paramount interest in considering the cost factor in surgical-medical insurance, is the fact that we have the highest female employment of any state in the country. For example, of those engaged in manufacturing 38 per cent of the employment in the major industries in the State is female. According to data accumulated by the Division of Statistics and Census of the State Department of Labor certain industries have as high as 50 per cent women in their employment. Examples: the textile industry as a whole, with approximately 58,000 workers, has 26,700 women employed; the jewelry trades have 50.6 per cent women, showing approximately 6,500 females employed of a total employed group of 13,000; electrical machinery has 42.6 per cent with 2,300 females out of an estimated 5,500; and the rubber industry, 3,320 females out of an estimated 6,500, for a percentage of 50.1.

These figures take on added significance in the consideration of surgical-medical insurance. The higher incidence of illness for females is a matter of record, and therefore, a determining factor in the writing of health insurance under any sponsorship. The medical statistics of the State cash sickness compensation program for the benefit year 1944-1945 offer striking example of the proportionately higher incidence of illness in female employees than males, in spite of the fact that the employed population is prepondantly male. For this benefit year there were 17,029 males of all ages to receive illness benefits, while the number of females, married and single, who were compensated for illness totaled 20,644.

Insurance companies do not gamble. They base their reports and estimates on statistical facts and therefore the female employment situation in Rhode Island, more so than in other states, will affect the group insurance premium. The extent to which it will affect the premium charge for surgical insurance is best illustrated by the rates projected by one outstanding national insurance company as follows:

Where Percentage of Female Employees is—	Premium Charge for Employee alone would be—
Less than 11 per cent	$ .57
11 — 21 per cent	.66
21 — 31 per cent	.71
31 — 41 per cent	.77
41 — 51 per cent	.83

Hence, within the textile industry, for example, the workers in a cotton mill with 50.7 female employment might be subject to a premium charge seventeen cents higher than those in cotton finishing where the female employment is but 17.3 per cent. A favorable aspect in regards to a group contract with private insurance, however, would be the premium refund at the end of the policy year on the basis of a good experience.

Thus, it is apparent that our employment situation presents an insurance cost penalty that is unavoidable. The problem is projected in this report mainly to point out clearly that a comparison of premium rates for similar services in another state cannot be fairly compared with any established in competitive trade here without an understanding of the factors influencing that rate.

Is There a Demand for Surgical Insurance?

Thirdly, the Committee has given consideration to the need for surgical insurance, and more particularly the demand for it. There is no way of estimating at this time the number of surgical procedures performed in the office or the home, provision for which is contemplated under the surgical insurance plans considered by the Society. But a study of hospitalized surgical operations in Rhode Island hospitals for the year 1944 showed a total of 28,151 operations, exclusive of births at Providence Lying-In Hospital. How many of these operations were traceable to occupational illness or disability, and thereby compensible under the workmen's compensation law, how many were done on free service at the hospitals, and how many were veterans is not known to the Committee. But we do feel that the tendency among the general public is to regard the protection against occupational disability as paramount, and since compensa-

tion is provided for such accidents and illnesses there is a reluctance to purchase insurance for non-occupational disability.

We believe, however, that the availability of several low cost contracts to provide surgical coverage for the worker and his dependents for non-occupational illness, properly publicized, and backed by the support of the medical profession, would overcome this reluctance. We believe the people of Rhode Island are both willing and anxious to secure protection against the costs of preserving their good health, and we believe that the people will recognize in competitive private insurance programs an answer to this question far more satisfactory than any compulsory or monopolistic tax-supported plan.

Income Limits

The Council on Medical Service of the American Medical Association in its 1947 report on Voluntary Prepayment Medical Care Plans makes the interesting observation regarding income limits that

> "The use of income limits is an important factor to the public because its intended function is to protect a specified income group from additional charge. However, studies of physicians' charges in relation to patients' incomes actually show that even in cash indemnity plans the income limit theory is closely adhered to by the profession."

In this connection your Committee notes with interest that the surgical insurance plan in Delaware is written as a rider to the hospitalization contract, and there is no income limit. Yet this surgical plan has sold more than 100,000 subscribers and both the public and the profession have been satisfied.

However, we believe that the medical profession would make a tremendous contribution to the progress of social insurance on a voluntary basis if it adopted the proposal that persons whose annual family income is under certain limits shall receive complete surgical service for the indemnity fee listed.

Neither the hospitalization program, nor any other community organization or group of individuals has come forward with a contribution equal to this proposed by the medical profession.

In arriving at income limits below which the contract would provide the service at no additional fee your Committee again points out that local conditions must be carefully considered. Family buying power in Rhode Island exceeds the national average by 26.6 per cent and per capita savings are the fourth highest in the nation. In seven war bond drives Rhode Island exceeded its quota by an average of 64 per cent and at the war's end had bought more than $81 million worth of E-bonds alone.

Sales Management, in its Survey of Buying Power shows the average family buying income (gross income less income tax) for Rhode Island for 1946 to be $4,307, and the per capita income $1,188, both figures being well above the national average.

In proposing the utilization of private insurance companies to offer a wide coverage on a competitive basis the Committee has not lost sight of the fact that the primary purpose of the Society's studies has been for the extension of medical service to persons in the lower income group. We have noted with interest that press reports, editorials and public comments, other than those by the Society, have discussed insurance for everyone, whereas the medical profession has consistently maintained that the greatest concern should be to offer aid to those whose income is limited and for whom a major illness necessitating a surgical operation involves an expenditure for which funds have not been budgeted or saved.

Since Rhode Island is one of the most highly industrialized of all states we can turn to the studies of the manufacturing industries for some index of average weekly earnings of workers, since employment in manufacturing industries represents 50 per cent of all workers. In 1946 the average weekly earnings in this group was $41.79, and for the first six months of this year it has been $45.04. Thus the individual average annual earning in 1946 was $2,173.08, and for 1947 on the basis of the first six months, $2,342.08.

Therefore, it is apparent that the proposal of the Committee that the annual family income limits for complete indemnity be set at $2,000 for the individual and at $3,000 for the family is liberal, and certainly goes far above what might be determined by any basis as a low income group. A family income beyond these limits would mean that the surgical indemnity fee would be paid towards the physician's total bill with the patient liable for an additional fee, if any.

Schedule of Indemnities

The master schedule of indemnity benefits as originally accepted by the House of Delegates when negotiations were under consideration with the Hospital Service Corporation of Rhode Island a year ago has been used by the Committee. The schedule has been carefully reviewed in conference discussions with physicians of major insurance companies and it has been amended slightly to clarify some of the procedures listed. The schedule is more liberal than most schedules now followed by insurance companies, and therefore, it is advantageous to the patient-subscriber.

continued on next page

In a great many states anesthesia and radiology are included under the Blue Cross hospitalization contract. They are not included in Rhode Island. The Committee, after careful study, has agreed that radiology does not constitute a surgical benefit as such under the program proposed and therefore it recommends that it be omitted from the schedule. However, the Committee believes that anesthesia, especially when done in the hospital, should be provided for under the surgical plan even though its inclusion adds appreciably to the basic premium charge. Provision is also made in the schedule for payments to surgical assistants when the maximum amount set forth for the operative procedure exceeds $49.

Recommendations

Of paramount importance to the Committee has been the task of developing not a single plan, but a Rhode Island Medical Society Program to embrace any insurance policy that will meet the minimum standards set forth by the Committee in the best interests of the public. Hours of study have been given to the consideration of the manner by which this might be accomplished.

After consideration of the legal as well as the practical aspects, the Committee believes that the objectives can be attained in the following manner:

The Committee recommends that the House of Delegates approve

(1) a revised statement of objectives and principles, and minimum standards of coverage (attached as Schedule A),

(2) the master schedule of indemnity benefits (attached as Schedule B), and

(3) a physicians' agreement (attached as Schedule C)

After such approval, all insurance companies duly licensed in the State of Rhode Island would be invited to submit their policy forms which they propose to offer in accordance with the principles laid down by the House of Delegates. Upon such submission, the appropriate representatives of the Society (and it is recommended that a new Committee on Health Insurance be organized by the House of Delegates for this purpose) would review each policy, and if they found that the benefits in the policy meet the minimum standards of coverage and that the promotion and sale of the policy will contribute toward the attainment of the objectives of the Society, the policy would be approved in all respects except for the premium rates, and the company would be authorized to use the statement, "the benefits provided in this policy are accepted and approved by the Rhode Island Medical Society" on the policy and in advertising and promotional literature in connection therewith.

The Committee recommends that every member of the House of Delegates study each of the attached schedules carefully and come to the meeting fully familiar with them. They have not been abbreviated so that they will be studied in their entirety.

Conclusion

In view of the foregoing your Committee recommends that the House of Delegates consider this complete report for possible adoption in order to increase the extent to which voluntary insurance against the cost of medical care is made available to the people of the state of Rhode Island.

We recognize that the program will have its flaws. But we are confident that time and experience will improve and strengthen the program and extend the coverage on a competitive low cost basis.

We know that the insurance will necessarily have to be sold at the beginning on a group contract basis, just as was the hospitalization insurance. But we are encouraged by the fact that our proposal is the first to our knowledge that has attracted the interest and support of all the major insurance groups in the nation, including life insurance companies offering disability coverage, thus indicating that groups of ten or more, and ultimately individuals, may be subscribers under the program.

The fundamental concern of the medical profession is the prevention of sickness and disability, and the alleviation and cure of ill health.

As members of the community the medical profession are faced with the same identical economic problems of life as any other citizens. We are conscious of the costs of all the necessities of life of which medical care is but one. We have continually pointed out the many community problems influencing the standard of health and contributing to the total cost of medical care.

As members of the community we are conscious of the economic pattern that governs the lives of the people. Others of our members have pointed out before that good health is for the most part a natural heritage, and therefore the necessity of including a provision in the family budget for the costs to protect that heritage must not be overlooked.

This proposal which we recommend to the Society for adoption, and which we sincerely believe will find a ready response from the insurance industry of America, and which we hope will strike an equally responsive chord with the people of this State, is presented as a contribution to the

economic welfare of the community in which we live and work. It represents a sincere and honest effort on the part of the medical profession to aid not only those in the lower income group, but all the people, to budget for the unexpected and therefore often catastrophic results from disabilities necessitating surgical procedures for the restoration of good health.

ROCCO ABBATE, M.D., *Chairman*
CHARLES J. ASHWORTH, M.D.
J. MURRAY BEARDSLEY, M.D.
CHARLES L. FARRELL, M.D.
ARCADIE GIURA, M.D.

SCHEDULE A

Objectives and Principles of the Rhode Island Medical Society's Program for Voluntary Prepaid Non-Occupational Surgical and Obstetrical Insurance

The Rhode Island Medical Society (hereinafter sometimes referred to as the "Society") establishes as its objectives:

(1) To increase the extent to which voluntary insurance against the cost of medical care is made available to the people of the State of Rhode Island;

(2) To increase the effectiveness of such insurance through the voluntary cooperation of its members;

(3) To make such insurance available at the lowest practicable cost under competitive conditions; and

(4) To safeguard the physician-patient relationship deemed necessary by the Society to maintain and improve the high standards of medical care in the State of Rhode Island.

In order to attain such objectives the Society hereby sponsors a program of prepaid surgical and obstetrical insurance on the following principles:

(1) Injuries compensable under the Workmen's Compensation Law will not be covered in this program.

(2) The attached Master Schedule of Surgical Indemnities shall serve as a standard for use in connection with this plan where services are rendered up to and including a semi-private level, including such extra services as are deemed necessary by the surgeon; such Schedule is subject to change by the Society as conditions and experience warrant.

(3) The Society shall make a determined effort to obtain the consent of its members to participate in the plan. Participation shall mean the doctor's agreement with the Society to accept for a minimum of one calendar year the amounts in the Indemnity Schedule as full payment for the procedures listed therein for persons coming within the defined income group and their dependents insured under policies endorsed by the Society, as hereinafter set forth; provided such persons authorize that the benefits be paid by the insurance carrier direct to the physician.

(4) The Society shall make a determined effort to interest all duly licensed insurance companies and the Blue Cross in underwriting this plan. (Insurance company as hereinafter used refers to such a duly licensed insurance company or the Blue Cross.)

(5) Persons who shall receive surgical service for the indemnity fee listed in the Master Schedule of Surgical Indemnities include (a) individuals whose gross incomes do not exceed $2,000 per year and whose gross aggregate family incomes do not exceed $3,000 per year, and (b) individuals with dependents whose gross aggregate incomes do not exceed $3,000 per year, at the time of disability. Persons whose gross incomes exceed such limits shall have such indemnity fee applied towards the physician's total bill with such persons liable for any additional fee charged by the physician. These income limits are subject to change by the Society from time to time as warranted by conditions and experience.

(6) Each insurance company desiring to have its policies approved under this program shall submit to the Society the policy form or forms it plans to offer with the endorsement of the Society; such policy forms may include coverage in excess of that required by the Society for endorsement; provided, however, no policies shall be sold under this program before January 1, 1948.

(7) The Society shall review the policy forms and, if it finds that the Indemnity Schedules and other provisions in such policies, except as hereinafter noted, meet the minimum standards of coverage and believes that the promotion and sale of such policies will contribute toward the attainment of the objectives of its program, the Society shall forthwith grant its consent to the use by the company of the statement "The Benefits in this Policy are Accepted and Approved by the Rhode Island Medical Society" on such policy forms and in its advertising and promotional literature to be used in connection therewith; for the sake of simplicity, some of the less frequent types of procedures may

continued on next page

be omitted from the printed fee schedule in such policy forms, with the understanding that the attached Indemnity Schedule shall govern for unprinted procedures.

(8) All advertisements and promotional literature involving the Society's name shall be submitted to the Society at least fourteen days (excluding Sundays and holidays) before its intended use and the use of any such material shall be subject to disapproval of the Society on reasonable notice to the company.

(9) The Society shall be under no obligation whatsoever to review the premium rate or rates of those policies submitted for its approval under this program, since it is the desire of the Society to permit such rates to seek their natural levels through competition; however, the Society may request any company to furnish it with the rates at which the policies are to be or are being offered to the public and the company shall comply with such request within a reasonable time.

(10) The Society may request experience and enrollment figures from any insurance company and the company shall comply therewith in reasonable time, but such statistics shall not be made public in any manner which will identify any of the statistics with any one insurance company without that company's consent.

(11) An insurance company whose policies are approved under this plan shall not interfere with the insured's free choice of a physician.

(12) The Society shall not interfere (except as hereinafter provided in Paragraph 16) with an insurance company's rights and obligations under the terms of the policy form endorsed by the Society, provided, however, that payments made by the insurance company under such policy for procedures not listed in the attached Indemnity Schedule shall be subject to review by the Society.

(13) An insurance company whose policies are approved under this plan may at any time, upon fourteen days' prior written notice to the Society thereof (Sundays and holidays excluded), cease to issue its policies with the Society's endorsement. Thereafter, such company shall not use the endorsement of the Society on any new policies issued or in advertising or promotional literature in connection therewith. In such event the Society's endorsement of all outstanding policies of said company shall nevertheless continue until the next following anniversary date of issue of such policies.

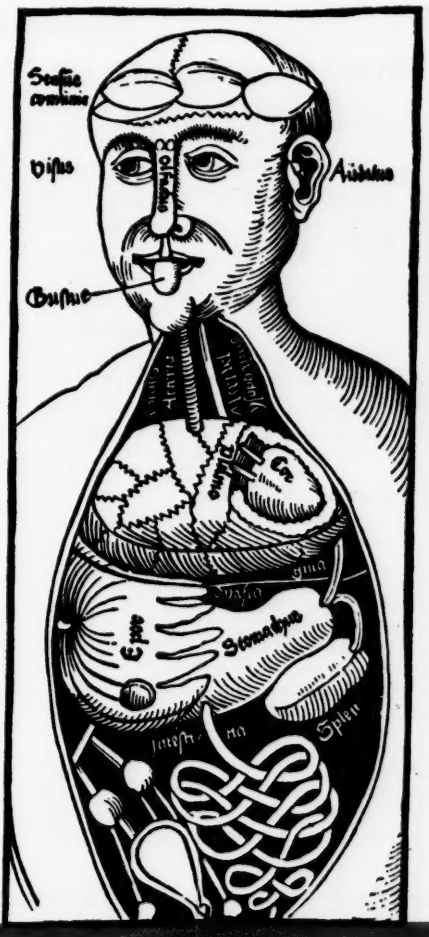
(14) The Society may at any time, upon fourteen days' prior written notice to an insurance company (Sundays and holidays excluded), withdraw its consent to the use of its endorsement on any policy form and in advertising and promotional literature in connection therewith. In the event of such withdrawal (a) the company shall cease forthwith to use such endorsement on all new policies on such forms and in advertising and promotional literature in connection therewith; (b) the Society's endorsement of all outstanding policies of said company on said form shall nevertheless continue until the next following anniversary date of issue of such policies; and (c) the company shall have no cause of action against the Society except upon proof of malice.

(15) An insurance company whose policies are approved under this program shall not be prevented thereby from issuing policies which are not endorsed by the Society so long as such policies and the advertising and promotional literature in connection therewith do not use the name of the Society.

(16) An insurance company whose policies are approved under this plan shall not make it a condition of selling any policy form endorsed by the Society that the prospective policy holder shall take any additional or other form of insurance.

(17) A Health Insurance Committee of the Society shall confer with the insurance companies on problems which arise in connection with this program, for the purpose of taking appropriate action upon administrative matters, complaints of persons insured and/or participating doctors, and, if so authorized, to act in the name of the Society to carry out these principles.

Anatomic woodcut:
Title page from
Pyligk Compendium;
1516—Courtesy,
The Bettmann Archive



IN 1516:

Anatomic illustrations were crude; knowledge of the anatomy and the treatment of diseases of the heart and thoracic organs were extremely limited.

today:

SEARLE **AMINOPHYLLIN***

is widely employed in selected cardiac cases, bronchial asthma, paroxysmal dyspnea and Cheyne-Stokes respiration.

G. D. Searle & Co., Chicago 80, Illinois

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

*Searle Aminophyllin contains at least 80% of anhydrous theophylline

SEARLE RESEARCH IN THE SERVICE OF MEDICINE

SCHEDULE B

MASTER SCHEDULE OF SURGICAL INDEMNITIES

(Including usual pre- and post-operative hospital care)

I. *MULTIPLE PROCEDURES*

When more than one operation is performed at one time, payment will be made for each in accordance with this Schedule, subject to a maximum total of $150. Furthermore, the maximum total with respect to all operations due to the same or related cause which are performed during a continuous period of disability shall be $150. For this purpose all procedures performed through the same incision shall be considered one operation, and operations that are not separated by three months shall be deemed to have been performed during "a continuous period of disability".

II. *UNLISTED PROCEDURES*

In addition to the procedures listed in this Schedule, amounts shall be payable for cutting operations performed in a legally constituted and operated hospital while the patient is confined, other than as "out-patient". The maximum amounts for such procedures shall be determined in amounts consistent with those listed.

GENERAL SURGERY

Infections and Traumata

Abscesses incision and drainage, Furuncles excepted	$ 5.00
Deep cervical abscess	25.00
Carbuncle	25.00
Ulcer, surface excision	10.00
Tendon, repair, one primary	25.00
each additional	10.00
Maximum	100.00
Septic finger (tendon sheath involvement)	15.00
Septic hand (tendon sheath and compartments)	75.00
Lacerations, extensive, including debridement	25.00

Cysts

Cyst, sebaceous, removal	$10.00
Pilonidal cyst or sinus	50.00
Thyroglossal cyst, removal	100.00
Bronchial cyst, removal	100.00

Tumors

Tumors, benign external, removal	$10.00
Tumors, benign, removal deep	25.00
Epulis, removal	15.00
Parotid tumor, removal	75.00
Epithiolioma of face, surgical removal	25.00
Cancer of tongue, (resection or removal)	100.00
Same with neck dissection	150.00
Cancer of lip (local operation)	35.00
Same with neck dissection	125.00

Biopsy

Biopsy, superficial	$ 5.00
Biopsy, bone or bone marrow	15.00
Biopsy, needle aspiration	5.00

Glands

Glands, superficial, removal	$10.00
Dissection glands of neck, deep chain	100.00
Radical Axilla or groin	100.00

Thyroid

Thyroidectomy, subtotal	125.00
Ligation preliminary to thyroidectomy	25.00
Thyroidectomy, two-stage, subtotal (with or without ligation) Complete procedure	150.00
Parathyroidectomy	150.00

Breasts

Breast abscess, drainage	$25.00
Breast cyst or abscess, aspiration	10.00
Breast tumor, benign removal	35.00
Breast, radical removal, including axillary dissection	125.00
Breast, simple removal	75.00

Miscellaneous

Ligation, saphenous vein, low, including retrograde injection, if done	$25.00
Ligation, saphenous vein, high, (and combined) including retrograde injection, if done	40.00
Extensive varicose veins, one leg	50.00
(Multiple ligations on same or successive days)	
Same, bilateral	100.00
Toe nail, ingrown, removal radical	20.00
Stone, submaxillary or parotid duct	25.00
Removal of submaxillary salivary gland	50.00
Injection, varicose veins, complete procedure	25.00

ENDOSCOPY

(When preliminary and related to surgical service only)

Bronchoscopy, diagnostic, preceding surgery	$25.00
operative	50.00
Cystoscopy	
Observation (preceding surgery)	15.00
Ureteral catheterization	20.00
Operative	35.00
Gastroscopy	25.00
Laryngoscopy	
Diagnostic (by Laryngoscope)	10.00
Operative	25.00
Peritoneoscopy	25.00
Sigmoidoscopy and biopsy	10.00
Esophagoscopy	25.00

SPECIAL SURGERY

Thoracic Surgery

Pneumolysis	$75.00
Pleura, paracentesis	10.00
Empyema, closed drainage	25.00
Empyema, rib section	75.00
Phrenic nerve, crushing	25.00
Thoroceplasty (First stage or partial)	75.00
(Complete)	150.00
Thoracoplasty (complete)	150.00
Lobectomy	150.00
Aneurysmorraphy	150.00
Induction of artificial pneumothorax	25.00
Refills	5.00

Abdominal Surgery

Abdomen, paracentesis	$10.00
Herniotomy, single inguinal, femoral or umbilical	100.00
Herniotomy, bilateral inguinal or femoral	125.00

continued on page 746

NEO-SYNEPHRINE HYDROCHLORIDE... time-honored nasal decongestant—famous for over a decade of distinguished performance in relieving the upper respiratory symptoms of colds, sinusitis and allergic rhinitis. Supplied as ¼% and 1% in isotonic saline, ¼% in isotonic solution of three chlorides (Ringer's) with aromatics, ½% in water-soluble jelly.

NEO-SYNEPHRINE SULFATHIAZOLATE... a true chemical compound in clear solution 0.6%... provides the decongestive effect of ¼% Neo-Synephrine plus ample bacteriostatic action, with a minimal concentration of sulfathiazole... clears the nasal airways for greater breathing comfort... tends to limit the spread of infection caused by secondary invaders.

NEO-SYNEPHRINE WITH PENICILLIN... vasoconstrictor and antibacterial for use in acute and chronic sinusitis. Supplied as a combination package—when mixed each cc. contains at least 1000 units of penicillin in ¼% Neo-Synephrine Hydrochloride. Special buffer holds the pH of the mixed solution at 6.0... enhances the stability of penicillin in solution, helps restore normal acidity of nasal mucous membranes.

Product of STEARNS Research

Family Traits... Neo-Synephrine products are efficient, dependable, specific... act almost immediately—provide relief that lasts for hours... consistently effective on repeated application with minimal rebound congestion... virtually free of systemic side effects or local irritation.

Trade-Marks *Neo-Synephrine* (Brand of Phenylephrine) and *Neo-Synephrine Sulfathiazolate* Reg. U. S. Pat. Off.

Herniotomy, hiatus or diaphragmatic	150.00
Herniotomy, ventral or incisional	100.00
Esophageal diverticulum	125.00
Gastrotomy or gastrostomy	100.00
Gastrectomy	150.00
Gastro-enterostomy	125.00
Peptic ulcer, perforated, closure	100.00
Peptic ulcer, subtotal gastrectomy	150.00
Pyloric stenosis (Rammstedt's in infant)	100.00
Intestines, anastomosis	125.00
Intestines, (small) resection	125.00
Adhesions, freeing of	100.00
Laparotomy	75.00
Colon, resection	150.00
Colostomy	75.00
Appendectomy	100.00
Diverticulum, intestinal	100.00
Appendiceal, abscess, drainage	100.00
Subdiaphragmatic abscess	100.00
Cholecystectomy	125.00
Biliary surgical drainage—common duct and cholecystectomy	150.00
Common duct, resection or reconstruction	150.00
Cholecystostomy	100.00
Cholecysduodenostomy	125.00
Pancreas, drainage	100.00
Splenectomy	150.00

Proctology

Hemorrhoids, injection treatment, complete procedure	25.00
Hemorrhoid, thrombosis, incision	5.00
Hemorrhoids, internal	35.00
Hemorrhoidectomy	35.00
Fistulectomy, single, excision of tract	50.00
multiple, excision of tract	75.00
Fistulectomy, excision of fistulous tract	25.00
Fissurectomy	10.00
Polypectomy	25.00
Abscess, ischio-rectal or peri-rectal drainage	20.00
Carcinoma of rectum, resection	150.00
Perianal abscess, drainage	5.00
Prolapsed rectum, repair	100.00

Urology

Circumcision, infant not requiring anesthesia	5.00
Circumcision, excepting the above	15.00
Urethrotomy, external, except meatotomy	50.00
Urethrotomy, internal	50.00
Prostatic abscess	35.00
Prostatectomy, perineal	125.00
Prostatectomy, suprapubic—one stage including vasectomy	125.00
Prostatectomy, suprapubic—two stage including vasectomy	150.00
Prostatectomy, transuretheral	100.00
Punch operation with suprapubic drainage	100.00
Perineoplasty with uretheral repair	75.00
Hydrocele, radical operation	50.00
Litholapaxy	50.00
Epididymectomy	50.00
Vasectomy (When not preliminary to prostatectomy)	25.00
Vesiculectomy	100.00
Varicocelectomy	50.00
Orchidopexy—One stage	75.00
Two stage	125.00
Orchidectomy simple	50.00
With gland dissection	100.00
Cystotomy or Cystostomy	75.00
Cystostomy with fulguration	100.00
Cystectomy	150.00
Ureter transplantation, single	100.00
bilateral	150.00
Bladder tumor, diverticula, etc. (resection)—open operation	125.00
Uretero-lithotomy	100.00
Nephrotomy	125.00
Nephrostomy	125.00
Nephrectomy	125.00
Nephropexy	100.00
Pyelotomy	100.00
Plastic on pelvis and ureter	125.00
Heminephrectomy	125.00
Excision and suture of urinary fistula (suprapubic)	50.00
(vaginal)	100.00
Penis amputation	75.00
Same with groin dissection	150.00
Plastic Hypo—and epispadias	125.00
Meatotomy	5.00
Caruncle excision	15.00
Caruncle fulguration	15.00

NEURO-SURGERY

Skull

Simple fracture (non-operable) with brain injury	$35.00
Depressed	75.00
Compound	150.00
Brain tumors	150.00

Brain Injuries; operable type

Extradural hematoma	$150.00
Subdural hematoma	150.00
Exploratory Trephination	
One side	50.00
Two sides	75.00
Intracortical clot	150.00
Arterio-venous fistula, intracranial	150.00

Spinal Cord

Section of anterior or posterior roots	150.00
Decompressive laminectomy	150.00
Removal of or exploration for an extruded nuclues, pulposus or ruptured intervertebral disc	150.00

Peripheral Nerve

Suture, decompression, or transplantation of single nerve	25.00
Each additional	10.00
Maximum	100.00
Pneumonenchephalogram	25.00
Ventriculogram	35.00
Spinal cord tumors	150.00
Operation for pain associated with malignancy or similar untreatable disease requiring intraspinal nerve sections or cordotomy	150.00

Miscellaneous

Section of sensory root for 5th nerve neuralgia	150.00
Section of vestibular nerve for Meniere's disease or aural vertigo	150.00
Operation for scalenus anticus syndrome	50.00
Craniotomy for brain abscess	150.00
Craniotomy for conditions not listed herewith	150.00
Bilateral orbital decompression	150.00
Choroidectomy for hydrocephalus	150.00
Excision of meningocele	75.00
Lumbar puncture (with fracture or operative work only) (diagnostic excluded)	5.00

Sympathetic System

Unilateral lumbar sympathectomy	$100.00
Bilateral lumbar sympathectomy	150.00
Resection of pre-sacral plexus	150.00
Bilateral, thoraco lumbar sympathectomy	150.00

continued on page 748

OBSTETRICS

Pregnancy, delivery (Does not cover prenatal and postnatal home and office care.)	$50.00
Miscarriage (curettage)	25.00
Caesarean section, vaginal	100.00
Caesarean section, abdominal	100.00
Pregnancy, ectopic	100.00

GYNECOLOGY

Bartholin's gland, incision	$ 5.00
Bartholin's gland, excision	25.00
Labial tumors and cysts, removal	20.00
Atresia of vagina, plastic	50.00
Fistula, recto-vaginal	100.00
Fistula, vesico-vaginal	100.00
Cul-de-sac, drainage	35.00
Cauterization or conization of cervix	10.00
Dilatation with or without curettage or cauterization	25.00
Uterine polyp removal with dilatation and curettage	25.00
Cervical polyp removal	5.00
Trachelorrhaphy	35.00
Cervix amputation	50.00
Oophorectomy or resection of ovaries	100.00
Hysterectomy	150.00
Myomectomy	100.00
Uterine flexions, etc., correction, (plus surgery of tubes and ovaries)	100.00
Same with vaginal plastic work	125.00
Salpingectomy	100.00
Salpingoophorectomy	100.00
Cystocele	50.00
Rectocele	50.00
Combined cystocele and rectocele	75.00
Prolapse operations (interposition, Manchester)	100.00
Vulvectomy	75.00
With groin dissection	150.00

OPHTHALMOLOGY

Foreign body, removal, within anterior or posterior chamber	$100.00
Cornea, parecentesis	20.00
Conjunctival suture	15.00
Conjunctival flap for corneal ulcer, etc.	25.00
Chalazion (excision, single	10.00
multiple	25.00
Lachrymal sac, removal	50.00
Entropion or ectropion, Ziegler's puncture	30.00
Entropion or ectropion, plastic operation	50.00
Entropion or ectropion, plastic operation grafts or flaps	75.00
Symblepharon, release	30.00
Pterygium	25.00
Corneal Ulcer—Cauterization	5.00
Corneal ulcer, deliminating keratotomy	25.00
Tarsorrhaphy, orbicularis paralysis	30.00
Ptosis, (single)	50.00
Strabismus, one or more muscles	75.00
Cataract, needling	40.00
Cataract, removal	100.00
Iridectomy	50.00
Glaucoma, filtration operation	100.00
Enucleation or evisceration	50.00
Same and implantation	75.00
Tumor, exenteration of orbit	100.00
Dacryocystorhinostomy	100.00
Detached Retina	125.00

OTOLOGY

Aural Polyp	10.00
Paracentesis tympani	10.00
Mastoidectomy, acute single	100.00
Mastoidectomy, acute bilateral	125.00
Mastoidectomy, radical single	150.00
Fenestration for otosclerosis	150.00

NOSE AND THROAT

Nasal polyps, removal	10.00
Antrum, Caldwell-Luc	50.00
Ethmoidectomy	35.00
Frontal sinus, radical	100.00
Turbinectomy	10.00
Submucous resection	50.00
Palatorrhaphy	100.00
Tonsillectomy and adenoidectomy	
Under 15	25.00
Over 15	35.00
Laryngectomy	150.00
Tracheotomy	50.00
Malignant disease, accessory sinuses (Radical Operation)—One sinus	100.00
Multiple	150.00
Malignant disease, tonsil and pharynx (Radical Operation)	100.00
Antrum puncture and irrigation	5.00
Antrum window	50.00

ORTHOPEDIC

Spinal fusion	$150.00
Cartilage of condyle of femur, removal of	75.00
Bone plate, removal of	25.00
Talipes	50.00
Semilunar cartilage, removal from joint	75.00
Tenotomy, simple, open	25.00
closed	15.00
Claw foot, except bone surgery—see foot stabilization	50.00
Coccyx, excision of	25.00
Arthrotomy, any major joint	75.00
Hallux Valgus, single radical operation	50.00
exostectomy	25.00
Osteomyelitis, sequestrum removal	25.00
Hallux valgus, bilateral radical operation for	75.00
Foot stabilization	150.00
Hammer toe, operation for	35.00
Arthrodesis of knee, hip, shoulder or elbow	150.00
Torticollis, operation for	75.00
Arthroplasty, any major joint	150.00
Hip joint, resection	150.00
Any other major joint, resection	100.00
Any joint, resection of, fingers or toes	25.00

AMPUTATIONS

Shoulder, Disarticulation	$125.00
Upper arm	50.00
Forearm	50.00
Hand	50.00
Finger, single	15.00
Each additional	10.00
Hip	125.00
Thigh	75.00
Knee	75.00
Leg	75.00
Toe	15.00
Each additional	10.00
Foot	50.00
Elbow	75.00
Scapulo thoracic amputation	150.00

DISLOCATIONS — CLOSED

Carpal bone, one	$25.00
Each additional	10.00
Clavicle	25.00
Elbow	25.00

continued on page 752

Finger, one	5.00
Each additional	5.00
Hip	35.00
Knee	35.00
Mandible	10.00
Metacarpal bone, one	15.00
Each additional	5.00
Metatarsal bone, one	15.00
Each additional	5.00
Patella	15.00
Rib	10.00
Shoulder	25.00
Tarsal bone, one	25.00
Each additional	10.00
Thumb	10.00
Toe, one	5.00
Each additional	5.00
Vertebra, one or more	100.00

SIMPLE FRACTURES — CLOSED

Lower jaw	$25.00
Carpal bone, one	25.00
Each additional	10.00
Clavicle	25.00
Coccyx	10.00
Femur	75.00
Tibia or fibula or both	50.00
Potts' or Cottons Fracture	75.00
Finger, one	10.00
Each additional	5.00
Humerus	50.00
Metacarpal bone, one	15.00
Each additional	10.00
Metatarsal bone, one	15.00
Each additional	10.00
Patella, closed	25.00
Nasal bone or bones—reduction	25.00
Pelvis	75.00
Radius or Ulna, or both	25.00
Rib, one or more	10.00
Sacrum	35.00
Scapula	25.00
Skull	35.00
Sternum	25.00
Tarsal bone, one (exclude os calcis and astragalus)	25.00
Each additional	10.00
Toe, one	10.00
Each additional	5.00
Vertebra, one or more	100.00
Os Calcis or Astragalus, or both	50.00

OPEN REDUCTIONS AND COMPOUND FRACTURES—

For compound fractures the maximum amount will be one and one-half times, and for fractures or dislocations requiring an open operation will be twice the amount shown for the corresponding simple fractures or dislocations, but in no case more than $150.

ADDITIONAL BENEFITS

In addition to the maximum amount set forth above, amounts will be allowable for Anesthesia, Transfusions, and Surgical Assistants as follows:

ANESTHESIA

To licensed physicians other than surgeons or assistant:

Where surgical indemnity is:	Anesthesia indemnity is:
Under $50	$10.00
50 to 99	15.00
100 to 150	20.00
Tonsillectomy	$8.00

Night emergency, minimum indemnity is to be $10.00

Transfusion, blood or plasma, (when given during any operative procedure) (Limit of two) $ 5.00

SURGICAL ASSISTANTS

When the nature of an operation is such that the services of an assisting licensed physician are necessary:

When surgical indemnity is:	Assistant's indemnity is:
$50 to $99	$10.00
100 to 150	15.00

SCHEDULE C

PARTICIPATING PHYSICIAN OF THE RHODE ISLAND MEDICAL SOCIETY

I hereby subscribe as a participating physician under the program sponsored by the Rhode Island Medical Society for voluntary prepaid surgical and obstetrical insurance, and the added insurance covering anesthesiology, as accepted and approved by the Rhode Island Medical Society.

In consideration of my being listed as such "Participating Physician", I hereby agree that my charges for the services included in the Master Schedule of Surgical Indemnities, as approved by the Rhode Island Medical Society under such program, and rendered to the insured or his dependents, shall not exceed the amount specified therein, provided the insured is (a) an individual whose gross income does not exceed $2,000 per year and whose gross aggregate family incomes do not exceed $3,000 per year, or (b) an individual with dependents whose gross aggregate income does not exceed $3,000 per year, at the time of disability.

I understand that persons whose gross incomes exceed such limits shall have such indemnity applied towards my total bill with such persons liable for any additional fee charged by me.

I understand that nothing in this agreement is intended to affect the relationship between the physician and his patient nor to restrict the physician in the exercise of his right to refuse to treat any patient for appropriate professional reasons.

I further agree to abide by the rulings of the Society's Committee on Health Insurance which will function under this program for the express purpose of facilitating any administrative problems that may arise.

I agree not to withdraw my consent as a participating physician prior to January 1, 1949.

.....M. D.

Address:

Date:

nontoxic

smaller dosage

treatment of inflammatory enteric diseases

'SULFATHALIDINE' *phthalylsulfathiazole*, developed by the Medical Research Division of Sharp & Dohme for treatment of inflammatory conditions of the intestine, is clinically nontoxic and effective in *smaller dosage* . . . 0.05 gm. to 0.1 gm. per kilogram of body weight daily. • 'SULFATHALIDINE' *phthalylsulfathiazole* maintains a high bacteriostatic concentration in the gastrointestinal tract, markedly alters the bacterial flora, and profoundly reduces Escherichia coli, clostridia and related organisms. Moreover, 'SULFATHALIDINE' *phthalylsulfathiazole* is effective even in the presence of a watery diarrhea. • Administered recently to 100 patients with inflammatory diseases of the intestine, 'SULFATHALIDINE' *phthalylsulfathiazole* was effective in the treatment of 90.* The clinician reported:

"It is my impression that phthalylsulfathiazole is less toxic and more bacteriostatic than any intestinal agent used previously and that, because it has these properties, smaller doses of the drug may be used to advantage."*

Indications: Ulcerative colitis, regional ileitis and ileojejunitis, and as an adjunct to intestinal surgery. • Supplied in 0.5-Gm. compressed tablets, bottles of 100, 500 and 1,000. Sharp & Dohme, Philadelphia 1, Pa.

*J. A. M. A. 129:1080. December 15, 1945.

'SULFATHALIDINE' SHARP & DOHME

Phthalylsulfathiazole

HOSPITAL ASSOCIATION OF RHODE ISLAND

EFFECT OF HIGH PRICES ON HOSPITALS

CARL A. LINDBLAD, Director, Roger Williams General Hospital, Providence

ALL HOSPITALS in recent years have found it necessary to make drastic increases in charges for services rendered to patients. As all physicians requiring hospital care for their patients are vitally interested in this subject, it is well to acquaint the medical profession with the problem that confronts hospital management.

During the war years when prices were stable and under control and when hospital bed occupancy was at a high level, our hospitals were in better financial condition than for many years preceding the war. Since price control has been dropped, higher labor and material costs has again placed many hospitals in the red, despite higher rates to patients and liberal contributions. Rates on interest derived from invested endowment funds has steadily declined and this income will no longer meet the mounting deficits. Large bequests from individuals is no longer to be expected and is not likely to be a factor in the future. This is due to the very high income and estate taxes prohibiting liberal bequests. It will therefore be necessary for the hospitals to secure the greater part of needed income from service rendered to patients.

Much has been published in the press lately on the high costs of modern hospital care. The figures given below are taken from information furnished by the Roger Williams General Hospital to its Board of Trustees in order that the Trustees might intelligently consider the problem. The facts are probably applicable to all of our hospitals.

PRICE COMPARISON

The following comprise the more heavily used items and are only a few of the many commodities used in the hospital. The prices are for the month of July, and unit costs are still on the increase and at the time of printing this issue of the Journal will no doubt be considerably higher:

	PRICE 1941	PRICE 1947	% INCREASE
Fuel Oil	.0345 gal.	.058 gal.	68%
Bed Sheets	8.50 doz.	23.66 doz.	179%
Gauze Sponges, 4x4	4.80 M	11.08 M	131%
Gauze Dressing Rolls	2.05 C-yds.	4.80 C-yds.	134%
Cut Gauze	2.05 "	4.80 "	134%
Cotton Balls	1.45 M	3.05 M	110%
Surgeons Gowns	16.60 doz.	31.00 doz.	87%
Canned Tomatoes, #10	4.75 "	11.90 "	150%
Coffee	.41 lb.	.74 lb.	49%
Fresh Milk	.08½ qt.	.13½ qt.	59%
Butter	.41 lb.	.74 lb.	80%
Eggs, fresh	.34 doz.	.72 doz.	112%
Beef, hinds	.21½ lb.	.58 lb.	170%

The Hospital Pay Roll has increased 80% during the same period, and if the hospitals are to meet the accepted industrial standard of a five day, forty-hour week, the Pay Roll would increase an additional 25%.

CHARGES TO PATIENTS

The hospitals have been reluctant to increase its charges to patients and have delayed increases in the hope that the situation might change. The charges have therefore not kept pace with increasing costs as will be noted from the percentage figures below,—

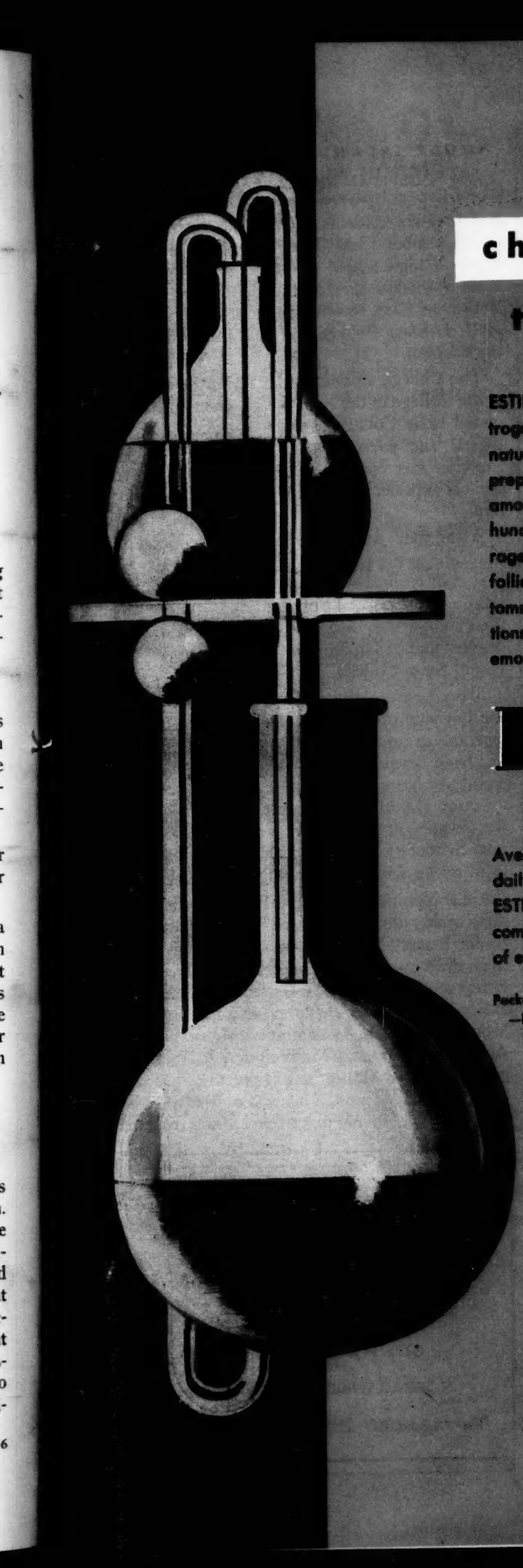
Single Rooms, (Private) 33% to 40% higher
Two Bed (Semi-private) 45% to 54% higher
Four Bed Rooms 75% higher

The wards are necessarily increased in rate to a larger extent as the costs of caring for a patient in the ward is but very little less than for the patient occupying a private room, and the rates have always been maintained at a considerable loss even before the present high price era. The per capita cost per day for each patient ranges from $11 to $14 in the hospitals in Rhode Island.

THE ROGER WILLIAMS GENERAL HOSPITAL SCHOOL OF NURSING

This school has been more fortunate than others in our area in securing applicants for admission. The number of students accepted is limited by the teaching facilities and the clinical material available, and in order to maintain standards prescribed for an accredited school, and to insure each student a well rounded and efficient course, the number accepted is usually set at 36 each year. An agreement with Rhode Island State College obligates the hospital to accept a limited number of students who are students in the Five Year program now availvale at State College.

continued on page 756



chemically similar to natural estrogens

ESTINYL (ethinyl estradiol) is "chemically similar to natural estrogen."[1] It is more active *orally* than any other synthetic or natural estrogen known today. ESTINYL is the first estradiol preparation that is efficacious by mouth in really minute amounts. It provides the economy inherent in low dosage. Five-hundredths of a milligram daily is sufficient to relieve the average menopausal patient. ESTINYL, closely allied to the primary follicular hormone, does more than mitigate vasomotor symptoms. ESTINYL quickly relieves the common nervous manifestations and bodily fatigue, and replaces them with a sense of emotional and physical fitness.

ESTINYL

tablets

Average menopausal symptoms: One 0.05 mg. ESTINYL Tablet daily. Severe menopausal symptoms: Two or three 0.05 mg. ESTINYL Tablets daily. Many patients may be maintained in comfort with 0.02 mg. ESTINYL Tablet daily after initial control of estrogen deficiency.

Packaging: ESTINYL TABLETS of 0.05 mg.—pink, coated tablets and 0.02 mg.—buff, coated tablets, bottles of 100, 250 and 1,000.

1. Bickers, W.: Am. J. Obst. & Gynec. 51:100, 1946.

Trade-Mark ESTINYL—Reg. U.S. Pat. Off.

Schering CORPORATION
BLOOMFIELD, N. J.

HOSPITAL ASSOCIATION NOTES

continued from page 754

Thirty-six students were admitted to the School on September 15th. They were carefully selected from 89 high school graduates who filed applications for admission to the School this year. In February, 1948, ten students in the five-year course at R. I. State College will join them in classes at the hospital.

The College students who began their program at the College in the Fall of 1945 have already completed basic College courses in physiological, biological and social sciences. During the current Summer they completed a ten weeks period of preclinical experience at Roger Williams General Hospital.

After their fifth semester of academic study at the College the program will include a 120 weeks period of clinical study and experience in the Hospital and at affiliating institutions. At the end of their course, they will receive a Bachelor of Science degree and a diploma in nursing from Rhode Island State College.

Miss Louise White, R.N., M.A., Director of the Division of Nursing, Rhode Island State College, has general supervision of the program which has been developed in consultation with the Committee on Nursing Education of the State Department of Health. The faculty at the College and the Faculty at the Roger Williams General Hospital School of Nursing work together very closely in planning and carrying out the clinical program.

New appointments to the Faculty of the School of Nursing during the current year were: Miss Lydia Blaser, R.N., M. A., Director of Nursing; Miss A. Rose Fratantuono, R. N., B.S., Assistant Director of Nursing; Mrs. Olive L. Young, R.N., B.S., Instructor in Science; and Miss Claire M. Montminy, R.N., Assistant Instructor in Nursing Arts. Miss Florence M. Weigner, R.N., B.S., has been appointed Educational Director.

CHARLES V. CHAPIN HOSPITAL

The Charles V. Chapin Hospital is well known throughout the country for its work in contagious diseases. During recent years, there has been a rapid trend towards specialization and fulfillment of the requirements set up by the various boards for the different specializations. The care and treatment of contagious diseases is not recognized as a specialty in itself. For this reason, during the last few years, it had become increasingly difficult to obtain doctors for this training. The solution to this problem was relatively easy.

The Charles V. Chapin Hospital is ideally equipped and staffed for a children's hospital. In July, 1946, approval for the training of residents in pediatrics by the American Board of Pediatrics and the Council on Medical Education and hospitals of the American Medical Association was granted. Certain requirements of the board which could not be filled by the hospital were arranged for by affiliation with the following outside assignments: Well-Baby Clinics conducted by the State Department of Health and Providence Health Department; New-Born Babies, Pawtucket Memorial Hospital; Child Guidance Clinics, Emma Pendleton Bradley Home, and Mental Hygiene Clinic. A new modern medical library for the staff has been established with every necessary book and periodical available. At the present time, there is a great demand for pediatric appointments at the Chapin which, we hope, and have no reason to doubt, will continue indefinitely.

The Charles V. Chapin Hospital, since its establishment, has always had a salaried resident staff. This policy does entail some expense, but has many advantages. An experienced, trained man in pediatrics and contagious diseases is always on duty in the hospital and sees every case soon after admission day or night. The proper treatment instituted without delay is in many cases life saving.

It might be well to remind the medical profession that cases may be admitted to this hospital from anywhere in the state.

A new training course for nurses in the psychopathic department has been established.

THE JOHN F. KENNEY ANNUAL CLINIC OF THE MEMORIAL HOSPITAL INTERNES' ALUMNI ASSOCIATION

at The Memorial Hospital, Pawtucket, Rhode Island on Wednesday, October 29, 1947

MORNING SESSION (9:30 a.m. to 12:55 p.m.) HENRY B. MOOR, M.D., *Chairman*

9:30– 9:35	GREETINGS	J. LINCOLN TURNER, M.D., *President Internes' Alumni Association*
9:40– 9:50	"SKIN GRAFTING"	BERT S. JEREMIAH, M.D.
9:55–10:05	"RESULTS OF THE TREATMENT OF ANGIOMA AT THE TUMOR CLINIC OF THE MEMORIAL HOSPITAL"	WILLIAM B. COHEN, M.D.
10:10–10:20	"HEMORRHAGE IN OTO-LARYNGOLOGY"	FRANCIS B. SARGENT, M.D.
10:25–10:45	"FRACTURES OF THE SHAFT OF THE TIBIA — TYPES AND TREATMENTS" — (Bone grafts and non-union)	ROBERT T. HENRY, M.D. *Collaborator:* JOHN H. GORDON, M.D.
10:50–11:10	"WILM'S TUMOR" — REPORT OF TWO CASES IN THE SAME FAMILY	MIHRAN A. CHAPIAN, M.D. *Collaborator:* EARL F. KELLEY, M.D.
	"LACERATION OF THE SCROTUM AND DISPLACEMENT OF TESTICLE"	STANLEY SPRAGUE, M.D.
11:15–11:35	"SUBACUTE BACTERIAL ENDOCARDITIS" — REPORT OF A CASE TREATED SUCCESSFULLY WITH PENICILLIN (34 months after treatment)	JACOB GREENSTEIN, M.D. *Collaborator:* RAYMOND W. YOUNG, PH.D.
11:40–12:05	"SYMPOSIUM ON RHEUMATIC HEART DISEASE"	EARL J. KELLY, M.D. BANICE FEINBERG, M.D. FRANCIS CORRIGAN, M.D. *Collaborator:* JOHN F. KENNEY, M.D.
12:10–12:35	"VISUALIZATION OF OBSTETRICAL TECHNIQUES USED IN TEACHING STUDENT NURSES"	J. LINCOLN TURNER, M.D. HENRY E. TURNER, M.D.
	"MODERN TRENDS IN OBSTETRICAL ANESTHESIA" (Low spinals, saddle block and Tohey technique)	WALTER J. DUFRESNE, M.D. HOWARD W. UMSTEAD, M.D.
12:40–12:55	"SYMPATHECTOMY IN THE TRAUMATIZED LIMB"	HANNIBAL HAMLIN, M.D. *Collaborator:* JESSE P. EDDY, 3d, M.D.
1:00– 2:00	LUNCHEON	

AFTERNOON SESSION (2:00 to 5:00 p.m.) GUY W. WELLS, M.D., *Chairman*

1. "BLOOD AND PLASMA IN SURGICAL EMERGENCIES." DR. FIORINDO A. SIMEONE — *Assistant Prof. of Surgery, Harvard Medical School, and Assistant Surgeon, Massachusetts General Hospital.*
2. "THE USE OF STREPTOMYCIN IN TUBERCULOSIS." DR. DONALD S. KING — *Lecturer in Medicine, Harvard Medical School, and Physician to the Massachusetts General Hospital.*
3. "PRESENT CONCEPTS IN TREATMENT OF CANCER OF THE CERVIX." DR. C. LANGDON PARSONS — *Instructor in Surgery, Harvard Medical School, and Visiting Surgeon, Massachusetts General Hospital.*
4. "MANAGEMENT OF HEART FAILURE." DR. EDWARD F. BLAND — *Instructor in Medicine, Harvard Medical School, and Associate Physician, Massachusetts General Hospital.*

HOUSE OF DELEGATES
of the
RHODE ISLAND MEDICAL SOCIETY

Report of Meeting Held on September 15, 1947

A MEETING of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library on Monday, September 15, 1947. The meeting was called to order by Dr. Ruggles at 8:35 p.m.

The following Delegates were in attendance:

Rocco Abbate, M.D.
Charles J. Ashworth, M.D.
Robert Baldridge, M.D.
Philip Batchelder, M.D.
Alex M. Burgess, M.D.
James Callahan, M.D.
Peter Pineo Chase, M.D.
Paul C. Cook, M.D.
G. Edward Crane, M.D.
Frank B. Cutts, M.D.
Morgan Cutts, M.D.
William P. Davis, M.D.
Donald DeNyse, M.D.
Charles L. Farrell, M.D.
David Freedman, M.D.
Isaac Gerber, M.D.
Henry Hanley, M.D.
Robert Henry, M.D.
William A. Horan, M.D.
Russell R. Hunt, M.D.
Albert H. Jackvony, M.D.
Walter S. Jones, M.D.
Louis I. Kramer, M.D.
Herman A. Lawson, M.D.
Earl J. Mara, M.D.
James M. McCarthy, M.D.
Louis Morrone, M.D.
John C. Myrick, M.D.
Joseph C. O'Connell, M.D.
Patrick I. O'Rourke, M.D.
Arthur H. Ruggles, M.D.
Daniel V. Troppoli, M.D.
Frederick A. Webster, M.D.

Others present were Dr. Arcadie Giura, member of the Surgical Study Committee, Mr. Charles Williamson, Legal Counsel for the Society, Mr. Henry Locke, Chairman of the Insurance Committee, and Mr. John E. Farrell, Executive Secretary.

Dr. Ruggles announced that the meeting would be devoted entirely to the Surgical Study Plan, and he expressed thanks to the Committee for the hours of time and thought they had spent on the work for the Society.

A copy of the supplemental report was distributed to each member and Dr. Abbate explained that it had not been mailed to the House as the regular report had been because it was completed too late to have it reach each member prior to the meeting. Dr. Abbate read the Supplemental Report explaining it as he went along.

Dr. Abbate explained that the supplemental report dealt wholly with conferences with the Blue Cross and he made it clear that the Committee had given them all the help possible.

Dr. Ruggles asked for questions or comments on the Supplemental Report. Dr. C. L. Farrell moved that the report be laid on the table. The motion was seconded and passed.

Since the House had received copies of the main report Dr. Abbate noted several corrections made by legal counsel, and then presented the report section by section. Discussion of various sections is summarized as follows:

INCOME LIMITS

Dr. W. S. Jones posed the question of whether the income limit was to mean gross income, or income after taxes had been deducted. The point was discussed and it was noted that in all plans the income limit is for gross income.

Dr. Baldridge raised the question of estates, citing as an example a man who has no actual income but who has an estate of $66,000. This man can have his cancer removed as a poor man. He stated that he believed this to be a gross injustice to the medical profession. Dr. Abbate pointed out that there would be a committee to settle the disputes such as illustrated when they do arise.

Dr. Jones pointed out further that the doctor "didn't have to take the patient." There is nothing in the plan that makes it mandatory to take any patient.

There was discussion relative to "semi-private" patients, which again brought up the fact that estates should be judged and limited. Dr. Ruggles stated that these problems could be better solved after the program has started and experience had been gained as to what present the real problems.

Radiology

Dr. Batchelder felt that Radiology should be included in the program as it is in most of the sixty-four plans already in practice. He remarked that particularly in fracture work it was going to be difficult to explain to the patient that X-ray was not included.

Dr. Abbate stated that the Committee felt that in the beginning it should leave out Radiology as not being an actual surgical procedure; then as the program progresses add extras such as Radiology. Dr. Farrell pointed out to the House that it was mostly a question of getting $15 worth of treatment and having to raise the premium rates, and that in most cases it would be easier for the individual to pay for X-ray out of his own pocket than to have to raise the premium for this one additional benefit.

continued on page 762

HOUSE OF DELEGATES REPORTS

continued from page 760

There was lengthy discussion in which Dr. Farrell stated again that it wasn't worth it to give the patient only $15 worth of X-ray in one year and up the cost of the plan 10 per cent. To Dr. Gerber's statement that the patient won't know the difference, Dr. Farrell stated that the patients have to be taught that the plan does not cover *everything,* but only certain things. The Committee put X-ray in the schedule in the beginning, but after much discussion and thought the Committee came to the conclusion that it was best to leave it out. Anesthesiologists and surgical assistants are included, so the patient would have money of his own to cover other expenses such as X-ray.

Dr. Gerber wanted to know if there would be sufficient publicity so that the public would be aware of these omissions. Dr. Abbate answered that there would be. He said the Committee had done everything it could to keep this plan at as low a cost as possible and when the Society puts in a medical plan X-ray certainly would be included.

Dr. Batchelder moved that radiology, according to the schedule submitted by the Surgical Committee in 1946, be included. The motion was not seconded.

Schedule A

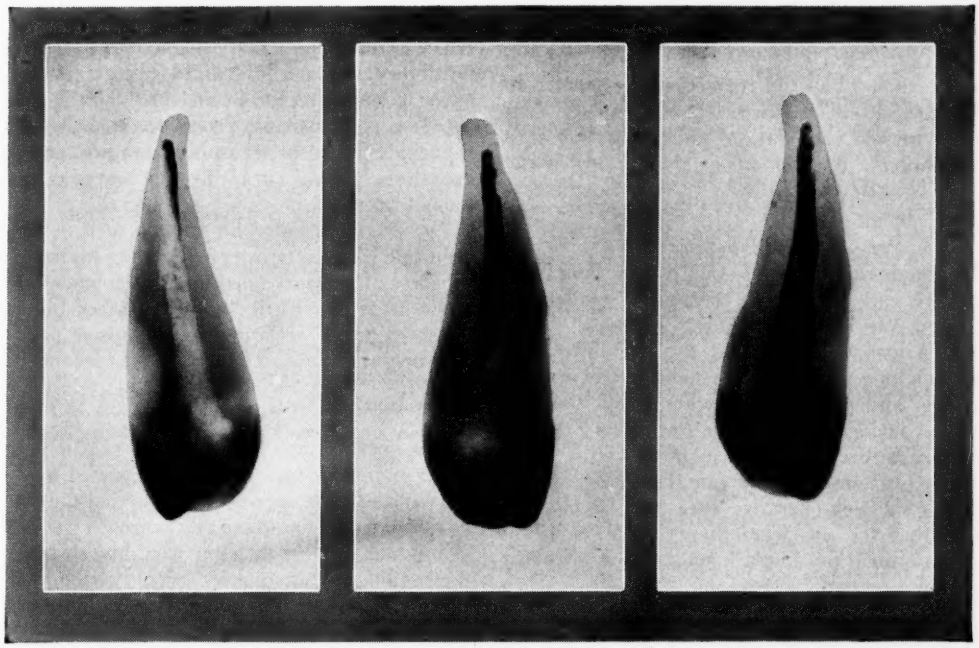
Dr. Batchelder pointed out that the use of "Fee" Schedule is an error. It should be "Indemnity" schedule, which it is called in Schedule B. However, it is referred to several times in Schedule A as "Fee." On a show of hands the majority wanted "Indemnity" inserted instead of "Fee" each time it occurred.

Dr. Baldridge opened discussion of Objective 2 relative to services being rendered on a semi-private basis. He stated that he thought this required further definition and clarification. The matter was discussed in detail and it was the general agreement that the section should be amended to explain that minimum semi-private care is meant and not extra services not usually given. It was further the opinion of the House that the semi-private basis should include anything that is considered necessary by the surgeon.

A discussion on limiting unearned income (estates) was held. It was brought out that there are some estates that earn nothing. It was the opinion that such questions and problems will have to be settled by the special committee to be named.

Dr. Davis asked what "Eligble" means. Dr. Abbate answered that "Eligible" means for "full coverage."

continued on page 764



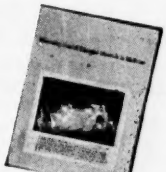
"Fiberglas is an inorganic, nontoxic, nonallergenic, nonsensitizing and chemically stable substance"

This summary is quoted from "Fiberglas Used as a Root Canal Filling Material" by Harry Maeth, D.D.S., in Dental Digest, Vol. 51, No. 10 (October, 1945) pp. 555-556.

The use of a special form of radiopaque Fiberglas* Yarn (available for experimental use only) to fill root canals of teeth offers several advantages, among them ability to verify stages of canal filling with the X-ray.

Several applications of standard Fiberglas products are described in the second edition of "Pioneering Uses of Fiberglas Materials in Medicine". Samples and a listing of the medically significant characteristics are also included.

Fiberglas may be helpful in some of your investigations or in solving some of your problems. Write for a copy of this interesting booklet today. Owens-Corning Fiberglas Corporation, Department 2036, Toledo 1, Ohio. Branches in principal cities.



In Canada: Fiberglas Canada Ltd., Toronto, Ontario.

*Fiberglas is the trade-mark, (Reg. U. S. Pat. Off.) for a variety of products made of or with fibers of glass by Owens-Corning Fiberglas Corporation.

OWENS-CORNING FIBERGLAS

HOUSE OF DELEGATES REPORTS

continued from page 762

On point 10 Mr. Williamson stated that there would be the addition of "and the company shall comply therewith after reasonable time," to be inserted.

In Sections 13 and 14 corrections were noted to read, "the Society's endorsement of all outstanding policies of said company on said form shall continue until *the next following anniversary of the date of issue of such policies.*" ("Until expiration thereof" being deleted.)

Pre- and Post-Operative Care

Dr. Davis raised the question of how long post-operative care should be continued. Under the proposed plan, there is no limit.

Dr. Ashworth stated that the committee had thought a long time about the question and decided that pre- and post-operative care meant the care that was incidental to hospitalization and the ordinary care that was necessary afterwards.

There was discussion about the cases that required long post-operative care and Dr. Farrell stated that the physician knows what is meant and if a limit is put in black and white it goes that way and no other.

Dr. Louis Morrone moved that post-operative care be limited to three weeks. There was discussion in which some of the members felt that certain cases should get special care and other members felt that care should be limited. Dr. Morrone amended his motion to read that post-operative care be three weeks while in the hospital; and one visit after surgery that was done in the office.

On a hand vote, ten were in favor of the motion and fourteen opposed.

Dr. Davis moved that this motion be referred back to the Committee for rewording and reclarification on the basis of the discussion at the meeting. The motion was seconded.

Dr. Mara stated that the people who are going to be covered by this insurance, the low-income group, are used to the Workmen's Compensation Act and they understand the word "usual," and further ,the Committee did not want the motion thrown back at them but apparently wanted the House to settle the question.

The motion was withdrawn.

Dr. Davis moved that where there is no specification in the schedule of indemnity benefits as to the extent of care to be provided for the amount listed for any particular procedure, it shall be taken to include the hospital examination, pre- and post-operative *hospital* care. The motion was unanimously accepted.

Dr. Davis amended his motion to provide that Schedule B of the new report relating to the master schedule of surgical indemnities be amended by the addition of the word "hospital" after the word "post-operative" relating to the usual pre- and post-operative care. The motion was seconded and passed.

Transfusions

The question was brought up as to who gets the $5 transfusion fee. It was suggested that the schedule be made specific and state that the amount be added to the anesthetist's charge. After discussion it was decided that this would be clear if just the heading "Transfusions" were deleted, and the transfusions fee be brought up as part of the "Anesthesia" paragraph.

Surgical Assistants

Some of the members thought that surgical assistants should get as much as anesthetists. A discussion followed. Dr. Hunt moved that transfusions be taken out entirely and the amount put on the surgical assistant's fee. After further discussion and debate in which it was pointed out that although the anesthetist does get a higher fee, very often he is held up after the operation and loses one or two succeeding operations, thereby not actually getting any higher fee in the long run than the surgical assistant who is free to go after the operation.

Dr. Jones moved that the indemnity schedule be approved and the House pass on to further business. The motion was seconded and on a voice vote passed.

Schedule C

Dr. Jones stated that the schedule should be amended so that the eligible group is taken care of under it. A discussion followed, and Dr. Jones then moved that the schedule be approved as amended. The motion was seconded and on a voice vote unanimously passed.

Dr. Ashworth moved that the entire Report be adopted as amended, and Dr. Burgess amended the motion by adding that the Committee be commended for its excellent work. The complete motion was seconded and passed unanimously.

Dr. Ashworth moved that all members of the House of Delegates sign as active participating physicians. A discussion followed in which it was questioned whether men who are not surgeons should sign up since they will not be able to participate actively in the plan. It was generally agreed that it would be a good morale booster if every Member signed up, whether he came under the plan or not.

After discussion Dr. Ashworth withdrew his motion and it was agreed that all the members of the House of Delegates present express their intention of signing as participating physicians by their endorsement of the plan.

New Health Insurance Committee

Dr. Henry moved that "A health Insurance Committee be formed composed of the present committee, and one additional member from each district society not at present represented. At all times there will be two from the Providence Medical Association and one from each of the other district societies. They shall be elected for staggered terms, two new, and two taken off each year. Each district will nominate one or more members and the President of the Rhode Island Medical Society will elect the Committee.

The motion was seconded and unanimously passed.

Physician Cooperation Question

Dr. Jones expressed doubt as to how the Providence physicians will take to the plan and he expressed the opinion that a ballot should be circularized asking if the physicians intended to sign.

Dr. Abbate moved that the President be empowered to send each member of the Society a copy of the report as amended by the House of Delegates and that a blank of Schedule C be sent to them for approval by signing and returning. The motion was seconded and passed.

Members were agreed that each district society have a meeting for the express purpose of discussing the surgical plan. Dr. Ruggles stated that the committee should educate the district societies.

Dr. Farrell raised the question of whether the Committee has the right to act for the Society. Dr. Burgess moved that the Surgical Plan Study Committee be authorized to act under the adopted plan for the Society. The motion was seconded and passed.

Publicity

Dr. Davis moved that the Committee Chairman, his Committee, and the President, be authorized to disseminate publicity on the report and proposed program. The motion was seconded and passed.

The meeting adjourned at 12:05 a.m.

Respectfully submitted,
MORGAN CUTTS, M.D.
Secretary

BOOK REVIEW

A HISTORY OF THE AMERICAN MEDICAL ASSOCIATION 1847-1947, by MORRIS FISHBEIN, M.D. W. B. Saunders Company, Philadelphia, 1947, $10.00

This massive volume of 1226 pages is not a history so much as a compilation of the widespread activities of the American Medical Association touching every branch of medical science and its relation to the public interest. As such, it is a valuable reference book. The Association is the brain child of Nathan Smith Davis, M.D. In the best American tradition, he was born in a log cabin in New York State and his struggles to obtain an education, and the hardships of the early years of practice are reminiscent of an Horatio Alger hero. After practicing in several small towns in his native state, he served for a year or two as Demonstrator of Anatomy in the College of Physicians and Surgeons in New York City until 1849 when he was called to the chair of Physiology and Pathology at Rush Medical College, Chicago. He spent the remainder of his life in that city and died, full of honors, at the age of 87, having practised 67 years. Dr. Davis had a flair for organization and believed that the numerous county and state medical societies of the country should join in a representative national organization in order to elevate the standards of medical education, licensure and public health; to maintain high ethical standards, to oppose charlatanism; to make available a better quality of medical service and to promote clinical and scientific investigation. These standards are still the ideal of the medical profession everywhere, and have not been greatly improved upon since his time. Dr. Fishbein has traced the accomplishments of the American Medical Association in pursuit of the above ideals with a detailed description of the achievements attained at each annual session. Biographies of the recipients of the Distinguished Service Medal occupy a small section of the book since they are only seven in number. Of especial interest are the biographies of the 101 Presidents of the Association. In almost every instance, the incumbent of this high office has been preeminent in his chosen field as well as a worker for higher scientific and ethical standards and improved medical organization. The history of the various councils and bureaus and the publications of the Association are discussed in separate chapters, each written by an authority on his particular subject. The chapters on the libel suits brought against the Association and the indictment and trial by the Federal Government make interesting reading and are well illustrated. In a recent issue of the New York Sunday Times — notably hostile to medical organization — the reviewer of this book praises the

continued on page 768

BOOK REVIEW

concluded from page 766

scientific accomplishments of the medical profession in a few brief sentences, but devotes most of his review to a bitter denunciation of the sociological activities of organized medicine, with no reference to the factual data contained in this volume.

ROLAND HAMMOND, M.D.

CHOLINE CHLORIDE IN CIRRHOSIS OF THE LIVER

concluded from page 728

Patient was admitted to the hospital for the fourth time for a check-up on June 16, 1947, almost three years since the last paracentesis. (See Laboratory Sheet.) At the beginning of her illness, five years ago, she weighed 104 pounds. She now weighs 114 pounds and looks like a woman thirty years of age instead of her real age of forty-five, in spite of having 106 paracenteses.

The only positive pathological findings — liver is palpable two and a half fingers below the ziphoid and laterally is lost under the costal margins. The spleen is palpable one finger below the costal margin and on deep inspiration extends to three fingers. The blood pressure is 120 over 80, pulse 72, temperature normal and respiration normal. Discharged June 18, 1947, as an arrested case of cirrhosis of the liver.

SUMMARY. The earlier a high protein, high vitamin B diet plus added Choline is instituted, the quicker the sick liver will be brought under control.

BIBLIOGRAPHY

[1] Wendell H. Griffith and Nelson J. Wade—II. The Interrelationship of Choline, Cystine, and Methionine in the Occurrence and Prevention of Hemorrhagic Degeneration in Young Rats. The Journal of Biological Chemistry, Vol. 132, No. 2, Page 635, February, 1940.

[2] G. O. Broun and R. O. Muether, Treatment of Hepatic Cirrhosis with Choline and Diet Low in Fat and Cholesterol, J. A. M. A. 118: 1403, April 18, 1942.

THE MOST IMPORTANT *but* IN SUCCESSFUL THERAPEUTICS . . .

For your many patients, *specific* therapeutic measures may have been effectively employed . . . *'but'* . . . successful rehabilitation may often *still* depend on an adequate supply of all *nutritional* requirements. GERILAC was formulated for this purpose.

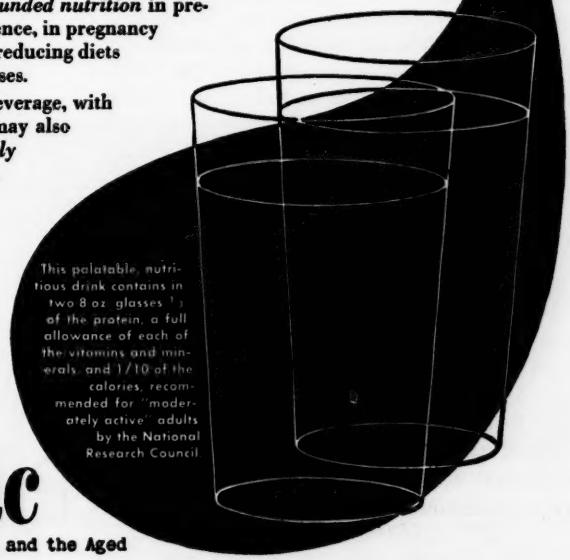
GERILAC's wealth of valuable milk proteins . . . its milk carbohydrate, lactose . . . its more-than-ample fortification with vitamins and minerals . . . its moderately low fat content . . . its palatability and easy digestibility—all suggest its routine use to assure *well-rounded nutrition* in pre- and postoperative conditions, in convalescence, in pregnancy and lactation, and in soft and liquid diets, reducing diets as well as in geriatric and even pediatric cases.

GERILAC has a pleasant, bland taste as a beverage, with and without the addition of flavors; and may also be readily used in cooking and baking. *Only water is required for dilution as a beverage.*

Write for Professional Literature and "Tasty Recipes" booklet.

BORDEN'S PRESCRIPTION PRODUCTS DIVISION
350 MADISON AVENUE, NEW YORK 17, N. Y.

GERILAC contains spray-dried whole milk and skim milk and is fortified with vitamins A and D, B-complex, C, together with niacinamide, monosodium phosphate, and iron citrate. Available in 1-lb. tins at pharmacies.



This palatable, nutritious drink contains in two 8 oz. glasses ⅓ of the protein, a full allowance of each of the vitamins and minerals, and 1/10 of the calories, recommended for "moderately active" adults by the National Research Council

Gerilac

A Dietary Supplement for Convalescents and the Aged

PRIZE CASE REPORT CONTEST

THE Providence Medical Association offers yearly a first prize of $50.00 and a second prize of $25.00 for the best report of a clinical case, or series of cases, submitted by a house officer or resident in one of the local hospitals and presented by him before a regular meeting of the Association, subject to the following conditions:

(1) The case, or series of cases, must have been studied by the contestant during his hospital service.

(2) The manuscript must be endorsed by the visiting man under whom the work was performed. This endorsement consists merely of a statement that the work described in the report was done on his service. The statement will be enclosed in a sealed envelope containing the name of the contestant. On the outside of the envelope will be placed a number, letter or motto which will be written in the same manner on the manuscript in place of the author's name.

(3) The manuscript must be typewritten and submitted in duplicate to the Executive Secretary of the Providence Medical Association during the hospital service of the contestant or within six months after the date of completion of service.

(4) When a report is judged worthy by the Contest Committee it will be accepted for the competition, and the envelope containing the name of the contestant will be opened. The contestant later will present his report in person before the Providence Medical Association at one of its regular meetings as arranged by the President. He will be notified well in advance of the date and hour of the meeting.

(5) Manuscripts received between January first and July first of any year will be considered for presentation at the October, November or December meetings. Those received after July first will be considered for presentation at the February, March, April, May or June meetings of the following year.

(6) Presentations should be straightforward reports of cases and should not include a review of the literature nor a general discussion of the subject illustrated.

(7) Contestants are not expected to submit illustrations with their manuscripts but are encouraged to use slides and tables if they so desire in their presentations before the Association.

(8) Two or more men may collaborate in submitting a report, in which case the presentation will be made by one of them and any prize money will be equally divided.

(9) In making awards the Committee will consider the following three factors, giving approximately equal weight to each:

Medical interest and value of the material presented.

Excellence of the written manuscript as a case report.

Excellence in the manner of presentation before the meeting. (Clearness and brevity are important. A time limit of 15 minutes is imposed.)

(10) Prize-winning case reports will be submitted to the editor of the RHODE ISLAND MEDICAL JOURNAL and if published the author will be furnished with one hundred reprints at the expense of the Providence Medical Association.

Prize Case Report Contest Committee of the Providence Medical Association

COMMITTEE:

CLARENCE E. BIRD, M.D., *Chairman*
FRANK B. CUTTS, M.D.
ALBERT H. JACKVONY, M.D.
LOUIS I. KRAMER, M.D.
ROBERT H. WHITMARSH, M.D.

SIXTH NEW ENGLAND POSTGRADUTE ASSEMBLY

Sponsored by the Medical Societies of

MAINE, NEW HAMPSHIRE, VERMONT, MASSACHUSETTS, RHODE ISLAND AND CONNECTICUT

COPLEY PLAZA HOTEL, BOSTON

OCTOBER 29-31

Program

WEDNESDAY, OCTOBER 29

MORNING SESSION

8:45 Registration

9:50 Assembly called to order by Dr. Leroy E. Parkins, *Chairman*

10:00 Clinical Diagnosis of Peripheral Vascular Disease, DR. HUGH MONTGOMERY

10:30 Treatment of Open Wounds of the Hand DR. MICHAEL L. MASON

11:00 15-minute intermission

11:15 Streptomycin in Tuberculosis and Other Diseases DR. WALSH MCDERMOTT

11:45 Office Gynecology: Diagnosis DR. RICHARD W. TELINDE

12:15 Luncheon. Copley Plaza Hotel
National Science Foundation Legislation MR. BRADLEY DEWEY

AFTERNOON SESSION

2:00 Office Gynecology: Treatment DR. RICHARD W. TELINDE

2:30 Treatment of Peripheral Vascular Disease DR. HUGH MONTGOMERY

3:00 Principles of Management of Burns DR. MICHAEL L. MASON

3:30 15-minute intermission

3:45 Present Status of Lobotomy and Shock Therapy in the Treatment of the Psychoses DR. HARRY C. SOLOMON

4:15 Common Dermatologic Problems in Medical Practice DR. MARION B. SULZBERGER

4:45 The Use of Sulfonamides and Penicillin DR. WALSH MCDERMOTT

THURSDAY, OCTOBER 30

MORNING SESSION

10:00 The Treatment of Infantile Diarrhea DR. L. EMMETT HOLT, JR.

10:30 Office Methods for the Diagnosis of Anal Disease (Motion Pictures) DR. LOUIS A. BUIE

11:00 15-minute intermission

11:15 Management of Diabetes Mellitus DR. HERMAN O. MOSENTHAL

11:45 Surgery of the Aged, DR. I. S. RAVDIN

12:15 Luncheon. Copley Plaza Hotel
The Problem of Cancer as Approached by the American Cancer Society
Speaker: DR. EDWIN P. LEHMAN
President, American Cancer Society

AFTERNOON SESSION

2:15 Psychiatry in Medical Practice DR. EDWARD WEISS

2:45 Office Treatment of Anal Disease DR. LOUIS A. BUIE

3:15 15-minute intermission

3:30 The Treatment of Syphilis with Penicillin DR. EVAN W. THOMAS

4:00 Problems of Nutrition in the Elderly Surgical Patient DR. I. S. RAVDIN

7:00 Dinner. Copley Plaza Hotel
Address — The Continuing Education of Physicians: A forecast of imminent changes DR. GEORGE BAEHR

FRIDAY, OCTOBER 31

Clinics will be conducted during the morning at various hospitals in Metropolitan Boston. Time, location, conductor and subject of each clinic to be announced.

An unusually interesting program will be presented. You are cordially invited to attend. Please mail applications early and reserve these dates.

The registration fee is $2.00, and should be forwarded by mail, if possible. Dinner will be $3.00, and the luncheons $2.00 each. Members may invite guests to luncheon and dinner if reservations are made in advance.

Physicians so desiring may be left on call (KENmore 5600).

Those who have not received an application blank or who desire further information should write to the Executive Committee, New England Postgraduate Assembly, 8 Fenway, Boston 15.